

1 **TITLE VI—MEDICAID AND SCHIP**  
2 **Subtitle A—Medicaid**  
3 **CHAPTER 1—PAYMENT FOR**  
4 **PRESCRIPTION DRUGS**

5 **SEC. 6001. FEDERAL UPPER PAYMENT LIMIT FOR MUL-**  
6 **TIPLE SOURCE DRUGS AND OTHER DRUG**  
7 **PAYMENT PROVISIONS.**

8 (a) MODIFICATION OF FEDERAL UPPER PAYMENT  
9 LIMIT FOR MULTIPLE SOURCE DRUGS; DEFINITION OF  
10 MULTIPLE SOURCE DRUGS.—Section 1927 of the Social  
11 Security Act (42 U.S.C. 1396r–8) is amended—

12 (1) in subsection (e)(4)—

13 (A) by striking “The Secretary” and in-  
14 serting “Subject to paragraph (5), the Sec-  
15 retary”; and

16 (B) by inserting “(or, effective January 1,  
17 2007, two or more)” after “three or more”;

18 (2) by adding at the end of subsection (e) the  
19 following new paragraph:

20 “(5) USE OF AMP IN UPPER PAYMENT LIM-  
21 ITS.—Effective January 1, 2007, in applying the  
22 Federal upper reimbursement limit under paragraph  
23 (4) and section 447.332(b) of title 42 of the Code  
24 of Federal Regulations, the Secretary shall sub-  
25 stitute 250 percent of the average manufacturer

1 price (as computed without regard to customary  
2 prompt pay discounts extended to wholesalers) for  
3 150 percent of the published price.”;

4 (3) in subsection (k)(7)(A)(i), in the matter  
5 preceding subclause (I), by striking “are 2 or more  
6 drug products” and inserting “at least 1 other drug  
7 product”; and

8 (4) in subclauses (I), (II), and (III) of sub-  
9 section (k)(7)(A)(i), by striking “are” and inserting  
10 “is” each place it appears.

11 (b) DISCLOSURE OF PRICE INFORMATION TO  
12 STATES AND THE PUBLIC.—Subsection (b)(3) of such sec-  
13 tion is amended—

14 (1) in subparagraph (A)—

15 (A) in clause (i), by inserting “month of a”  
16 after “last day of each”; and

17 (B) by adding at the end the following:  
18 “Beginning July 1, 2006, the Secretary shall  
19 provide on a monthly basis to States under sub-  
20 paragraph (D)(iv) the most recently reported  
21 average manufacturer prices for single source  
22 drugs and for multiple source drugs and shall,  
23 on at least a quarterly basis, update the infor-  
24 mation posted on the website under subpara-  
25 graph (D)(v).”; and

1 (2) in subparagraph (D)—

2 (A) by striking “and” at the end of clause

3 (ii);

4 (B) by striking the period at the end of  
5 clause (iii) and inserting a comma; and

6 (C) by inserting after clause (iii) the fol-  
7 lowing new clauses:

8 “(iv) to States to carry out this title,  
9 and

10 “(v) to the Secretary to disclose  
11 (through a website accessible to the public)  
12 average manufacturer prices.”.

13 (c) DEFINITION OF AVERAGE MANUFACTURER  
14 PRICE.—

15 (1) EXCLUSION OF CUSTOMARY PROMPT PAY  
16 DISCOUNTS EXTENDED TO WHOLESALERS.—Sub-  
17 section (k)(1) of such section is amended—

18 (A) by striking “The term” and inserting  
19 the following:

20 “(A) IN GENERAL.—Subject to subpara-  
21 graph (B), the term”;

22 (B) by striking “, after deducting cus-  
23 tomary prompt pay discounts”; and

24 (C) by adding at the end the following:

1 “(B) EXCLUSION OF CUSTOMARY PROMPT  
2 PAY DISCOUNTS EXTENDED TO WHOLE-  
3 SALERS.—The average manufacturer price for a  
4 covered outpatient drug shall be determined  
5 without regard to customary prompt pay dis-  
6 counts extended to wholesalers.”.

(2) MANUFACTURER REPORTING OF PROMPT  
PAY DISCOUNTS.—Subsection (b)(3)(A)(i) of such  
section is amended by inserting “, customary prompt  
pay discounts extended to wholesalers,” after  
“(k)(1))”.

12 (3) REQUIREMENT TO PROMULGATE REGULA-  
13 TION.—

(A) INSPECTOR GENERAL RECOMMENDATIONS.—Not later than June 1, 2006, the Inspector General of the Department of Health and Human Services shall—

(i) review the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, as amended by this section; and

(ii) shall submit to the Secretary of Health and Human Services and Congress such recommendations for changes in such

1 requirements or manner as the Inspector  
2 General determines to be appropriate.

3 (B) DEADLINE FOR PROMULGATION.—Not  
4 later than July 1, 2007, the Secretary of  
5 Health and Human Services shall promulgate a  
6 regulation that clarifies the requirements for,  
7 and manner in which, average manufacturer  
8 prices are determined under section 1927 of the  
9 Social Security Act, taking into consideration  
10 the recommendations submitted to the Sec-  
11 retary in accordance with subparagraph (A)(ii).

12 (d) EXCLUSION OF SALES AT A NOMINAL PRICE  
13 FROM DETERMINATION OF BEST PRICE.—

14 (1) MANUFACTURER REPORTING OF SALES.—  
15 Subsection (b)(3)(A)(iii) of such section is amended  
16 by inserting before the period at the end the fol-  
17 lowing: “, and, for calendar quarters beginning on or  
18 after January 1, 2007 and only with respect to the  
19 information described in subclause (III), for covered  
20 outpatient drugs”.

21 (2) LIMITATION ON SALES AT A NOMINAL  
22 PRICE.—Subsection (c)(1) of such section is amend-  
23 ed by adding at the end the following new subpara-  
24 graph:

1                   “(D) LIMITATION ON SALES AT A NOMINAL  
2                   PRICE.—

3                   “(i) IN GENERAL.—For purposes of  
4                   subparagraph (C)(ii)(III) and subsection  
5                   (b)(3)(A)(iii)(III), only sales by a manufac-  
6                   turer of covered outpatient drugs at nomi-  
7                   nal prices to the following shall be consid-  
8                   ered to be sales at a nominal price or  
9                   merely nominal in amount:

10                   “(I) A covered entity described in  
11                   section 340B(a)(4) of the Public  
12                   Health Service Act.

13                   “(II) An intermediate care facil-  
14                   ity for the mentally retarded.

15                   “(III) A State-owned or operated  
16                   nursing facility.

17                   “(IV) Any other facility or entity  
18                   that the Secretary determines is a  
19                   safety net provider to which sales of  
20                   such drugs at a nominal price would  
21                   be appropriate based on the factors  
22                   described in clause (ii).

23                   “(ii) FACTORS.—The factors de-  
24                   scribed in this clause with respect to a fa-  
25                   cility or entity are the following:

1 “(I) The type of facility or entity.

2 “(II) The services provided by  
3 the facility or entity.

4 “(III) The patient population  
5 served by the facility or entity.

6 “(IV) The number of other facili-  
7 ties or entities eligible to purchase at  
8 nominal prices in the same service  
9 area.

10 “(iii) NONAPPLICATION.—Clause (i)  
11 shall not apply with respect to sales by a  
12 manufacturer at a nominal price of covered  
13 outpatient drugs pursuant to a master  
14 agreement under section 8126 of title 38,  
15 United States Code.”.

16 (e) RETAIL SURVEY PRICES; STATE PAYMENT AND  
17 UTILIZATION RATES; AND PERFORMANCE RANKINGS.—  
18 Such section is further amended by inserting after sub-  
19 section (e) the following new subsection:

20 “(f) SURVEY OF RETAIL PRICES; STATE PAYMENT  
21 AND UTILIZATION RATES; AND PERFORMANCE  
22 RANKINGS.—

23 “(1) SURVEY OF RETAIL PRICES.—

24 “(A) USE OF VENDOR.—The Secretary  
25 may contract services for—

1                   “(i) the determination on a monthly  
2                   basis of retail survey prices for covered  
3                   outpatient drugs that represent a nation-  
4                   wide average of consumer purchase prices  
5                   for such drugs, net of all discounts and re-  
6                   bates (to the extent any information with  
7                   respect to such discounts and rebates is  
8                   available); and

9                   “(ii) the notification of the Secretary  
10                  when a drug product that is therapeuti-  
11                  cally and pharmaceutically equivalent and  
12                  bioequivalent becomes generally available.

13                  “(B) SECRETARY RESPONSE TO NOTIFICA-  
14                  TION OF AVAILABILITY OF MULTIPLE SOURCE  
15                  PRODUCTS.—If contractor notifies the Secretary  
16                  under subparagraph (A)(ii) that a drug product  
17                  described in such subparagraph has become  
18                  generally available, the Secretary shall make a  
19                  determination, within 7 days after receiving  
20                  such notification, as to whether the product is  
21                  now described in subsection (e)(4).

22                  “(C) USE OF COMPETITIVE BIDDING.—In  
23                  contracting for such services, the Secretary  
24                  shall competitively bid for an outside vendor  
25                  that has a demonstrated history in—



1 “(i) surveying and determining, on a  
2 representative nationwide basis, retail  
3 prices for ingredient costs of prescription  
4 drugs;

5 “(ii) working with retail pharmacies,  
6 commercial payers, and States in obtaining  
7 and disseminating such price information;  
8 and

9 “(iii) collecting and reporting such  
10 price information on at least a monthly  
11 basis.

12 In contracting for such services, the Secretary  
13 may waive such provisions of the Federal Ac-  
14 quisition Regulation as are necessary for the ef-  
15 ficient implementation of this subsection, other  
16 than provisions relating to confidentiality of in-  
17 formation and such other provisions as the Sec-  
18 retary determines appropriate.

19 “(D) ADDITIONAL PROVISIONS.—A con-  
20 tract with a vendor under this paragraph shall  
21 include such terms and conditions as the Sec-  
22 retary shall specify, including the following:

23 “(i) The vendor must monitor the  
24 marketplace and report to the Secretary

1 each time there is a new covered outpatient  
2 drug generally available.

3 “(ii) The vendor must update the Sec-  
4 retary no less often than monthly on the  
5 retail survey prices for covered outpatient  
6 drugs.

7 “(iii) The contract shall be effective  
8 for a term of 2 years.

9 “(E) AVAILABILITY OF INFORMATION TO  
10 STATES.—Information on retail survey prices  
11 obtained under this paragraph, including appli-  
12 cable information on single source drugs, shall  
13 be provided to States on at least a monthly  
14 basis. The Secretary shall devise and implement  
15 a means for providing access to each State  
16 agency designated under section 1902(a)(5)  
17 with responsibility for the administration or su-  
18 pervision of the administration of the State  
19 plan under this title of the retail survey price  
20 determined under this paragraph.

21 “(2) ANNUAL STATE REPORT.—Each State  
22 shall annually report to the Secretary information  
23 on—

1           “(A) the payment rates under the State  
2           plan under this title for covered outpatient  
3           drugs;

4           “(B) the dispensing fees paid under such  
5           plan for such drugs; and

6           “(C) utilization rates for noninnovator  
7           multiple source drugs under such plan.

8           “(3)     ANNUAL     STATE     PERFORMANCE  
9           RANKINGS.—

10           “(A) COMPARATIVE ANALYSIS.—The Sec-  
11           retary annually shall compare, for the 50 most  
12           widely prescribed drugs identified by the Sec-  
13           retary, the national retail sales price data (col-  
14           lected under paragraph (1)) for such drugs with  
15           data on prices under this title for each such  
16           drug for each State.

17           “(B) AVAILABILITY OF INFORMATION.—  
18           The Secretary shall submit to Congress and the  
19           States full information regarding the annual  
20           rankings made under subparagraph (A).

21           “(4) APPROPRIATION.—Out of any funds in the  
22           Treasury not otherwise appropriated, there is appro-  
23           priated to the Secretary of Health and Human Serv-  
24           ices \$5,000,000 for each of fiscal years 2006  
25           through 2010 to carry out this subsection.”.

1 (f) MISCELLANEOUS AMENDMENTS.—

2 (1) IN GENERAL.—Sections  
3 1927(g)(1)(B)(i)(II) and 1861(t)(2)(B)(ii)(I) of  
4 such Act are each amended by inserting “(or its suc-  
5 cessor publications)” after “United States Pharma-  
6 copoeia-Drug Information”.

7 (2) PAPERWORK REDUCTION.—The last sen-  
8 tence of section 1927(g)(2)(A)(ii) of such Act (42  
9 U.S.C. 1396r–8(g)(2)(A)(ii)) is amended by insert-  
10 ing before the period at the end the following: “, or  
11 to require verification of the offer to provide con-  
12 sultation or a refusal of such offer”.

13 (3) EFFECTIVE DATE.—The amendments made  
14 by this subsection shall take effect on the date of the  
15 enactment of this Act.

16 (g) EFFECTIVE DATE.—Except as otherwise pro-  
17 vided, the amendments made by this section shall take ef-  
18 fect on January 1, 2007, without regard to whether or  
19 not final regulations to carry out such amendments have  
20 been promulgated by such date.

1 **SEC. 6002. COLLECTION AND SUBMISSION OF UTILIZATION**  
2 **DATA FOR CERTAIN PHYSICIAN ADMINIS-**  
3 **TERED DRUGS.**

4 (a) IN GENERAL.—Section 1927(a) of the Social Se-  
5 curity Act (42 U.S.C. 1396r–8(a)) is amended by adding  
6 at the end the following new paragraph:

7 “(7) REQUIREMENT FOR SUBMISSION OF UTILI-  
8 ZATION DATA FOR CERTAIN PHYSICIAN ADMINIS-  
9 TERED DRUGS.—

10 “(A) SINGLE SOURCE DRUGS.—In order  
11 for payment to be available under section  
12 1903(a) for a covered outpatient drug that is a  
13 single source drug that is physician adminis-  
14 tered under this title (as determined by the Sec-  
15 retary), and that is administered on or after  
16 January 1, 2006, the State shall provide for the  
17 collection and submission of such utilization  
18 data and coding (such as J-codes and National  
19 Drug Code numbers) for each such drug as the  
20 Secretary may specify as necessary to identify  
21 the manufacturer of the drug in order to secure  
22 rebates under this section for drugs adminis-  
23 tered for which payment is made under this  
24 title.

25 “(B) MULTIPLE SOURCE DRUGS.—

1                   “(i) IDENTIFICATION OF MOST FRE-  
2                   QUENTLY PHYSICIAN ADMINISTERED MUL-  
3                   TIPLE SOURCE DRUGS.—Not later than  
4                   January 1, 2007, the Secretary shall pub-  
5                   lish a list of the 20 physician administered  
6                   multiple source drugs that the Secretary  
7                   determines have the highest dollar volume  
8                   of physician administered drugs dispensed  
9                   under this title. The Secretary may modify  
10                  such list from year to year to reflect  
11                  changes in such volume.

12                  “(ii) REQUIREMENT.—In order for  
13                  payment to be available under section  
14                  1903(a) for a covered outpatient drug that  
15                  is a multiple source drug that is physician  
16                  administered (as determined by the Sec-  
17                  retary), that is on the list published under  
18                  clause (i), and that is administered on or  
19                  after January 1, 2008, the State shall pro-  
20                  vide for the submission of such utilization  
21                  data and coding (such as J-codes and Na-  
22                  tional Drug Code numbers) for each such  
23                  drug as the Secretary may specify as nec-  
24                  essary to identify the manufacturer of the

1 drug in order to secure rebates under this  
2 section.

3 “(C) USE OF NDC CODES.—Not later  
4 than January 1, 2007, the information shall be  
5 submitted under subparagraphs (A) and (B)(ii)  
6 using National Drug Code codes unless the Sec-  
7 retary specifies that an alternative coding sys-  
8 tem should be used.

9 “(D) HARDSHIP WAIVER.—The Secretary may  
10 delay the application of subparagraph (A) or (B)(ii),  
11 or both, in the case of a State to prevent hardship  
12 to States which require additional time to implement  
13 the reporting system required under the respective  
14 subparagraph.”.

15 (b) LIMITATION ON PAYMENT.—Section 1903(i)(10)  
16 of such Act (42 U.S.C. 1396b(i)(10)), is amended—

17 (1) by striking “and” at the end of subpara-  
18 graph (A);

19 (2) by striking “or” at the end of subparagraph  
20 (B) and inserting “and”; and

21 (3) by adding at the end the following new sub-  
22 paragraph:

23 “(C) with respect to covered outpatient drugs  
24 described in section 1927(a)(7), unless information  
25 respecting utilization data and coding on such drugs

1       that is required to be submitted under such section  
2       is submitted in accordance with such section; or”.

3   **SEC. 6003. IMPROVED REGULATION OF DRUGS SOLD**  
4               **UNDER A NEW DRUG APPLICATION AP-**  
5               **PROVED UNDER SECTION 505(c) OF THE FED-**  
6               **ERAL FOOD, DRUG, AND COSMETIC ACT.**

7       (a) INCLUSION WITH OTHER REPORTED AVERAGE  
8   MANUFACTURER       AND       BEST       PRICES.—Section  
9   1927(b)(3)(A) of the Social Security Act (42 U.S.C.  
10   1396r–8(b)(3)(A)) is amended—

11               (1) by striking clause (i) and inserting the fol-  
12   lowing:

13                       “(i) not later than 30 days after the  
14                       last day of each rebate period under the  
15                       agreement—

16                               “(I) on the average manufacturer  
17                               price (as defined in subsection (k)(1))  
18                               for covered outpatient drugs for the  
19                               rebate period under the agreement  
20                               (including for all such drugs that are  
21                               sold under a new drug application ap-  
22                               proved under section 505(c) of the  
23                               Federal Food, Drug, and Cosmetic  
24                               Act); and



1 “(II) for single source drugs and  
2 innovator multiple source drugs (in-  
3 cluding all such drugs that are sold  
4 under a new drug application ap-  
5 proved under section 505(c) of the  
6 Federal Food, Drug, and Cosmetic  
7 Act), on the manufacturer’s best price  
8 (as defined in subsection (c)(1)(C))  
9 for such drugs for the rebate period  
10 under the agreement;” and

11 (2) in clause (ii), by inserting “(including for  
12 such drugs that are sold under a new drug applica-  
13 tion approved under section 505(c) of the Federal  
14 Food, Drug, and Cosmetic Act)” after “drugs”.

15 (b) CONFORMING AMENDMENTS.—Section 1927 of  
16 such Act (42 U.S.C. 1396r–8) is amended—

17 (1) in subsection (c)(1)(C)—

18 (A) in clause (i), in the matter preceding  
19 subclause (I), by inserting after “or innovator  
20 multiple source drug of a manufacturer” the  
21 following: “(including the lowest price available  
22 to any entity for any such drug of a manufac-  
23 turer that is sold under a new drug application  
24 approved under section 505(c) of the Federal  
25 Food, Drug, and Cosmetic Act)”; and

1 (B) in clause (ii)—

2 (i) in subclause (II), by striking  
3 “and” at the end;

4 (ii) in subclause (III), by striking the  
5 period at the end and inserting “; and”;  
6 and

7 (iii) by adding at the end the fol-  
8 lowing:

9 “(IV) in the case of a manufac-  
10 turer that approves, allows, or other-  
11 wise permits any other drug of the  
12 manufacturer to be sold under a new  
13 drug application approved under sec-  
14 tion 505(c) of the Federal Food,  
15 Drug, and Cosmetic Act, shall be in-  
16 clusive of the lowest price for such au-  
17 thorized drug available from the man-  
18 ufacturer during the rebate period to  
19 any manufacturer, wholesaler, retailer,  
20 provider, health maintenance organi-  
21 zation, nonprofit entity, or govern-  
22 mental entity within the United  
23 States, excluding those prices de-  
24 scribed in subclauses (I) through (IV)  
25 of clause (i).”; and

1 (2) in subsection (k), as amended by section  
2 6001(c)(1), by adding at the end the following:

3 “(C) INCLUSION OF SECTION 505(c)  
4 DRUGS.—In the case of a manufacturer that  
5 approves, allows, or otherwise permits any drug  
6 of the manufacturer to be sold under a new  
7 drug application approved under section 505(c)  
8 of the Federal Food, Drug, and Cosmetic Act,  
9 such term shall be inclusive of the average price  
10 paid for such drug by wholesalers for drugs dis-  
11 tributed to the retail pharmacy class of trade.”.

12 (c) EFFECTIVE DATE.—The amendments made by  
13 this section take effect on January 1, 2007.

14 **SEC. 6004. CHILDREN’S HOSPITAL PARTICIPATION IN SEC-**  
15 **TION 340B DRUG DISCOUNT PROGRAM.**

16 (a) IN GENERAL.—Section 1927(a)(5)(B) of the So-  
17 cial Security Act (42 U.S.C. 1396r–8(a)(5)(B)) is amend-  
18 ed by inserting before the period at the end the following:  
19 “and a children’s hospital described in section  
20 1886(d)(1)(B)(iii) which meets the requirements of  
21 clauses (i) and (iii) of section 340B(b)(4)(L) of the Public  
22 Health Service Act and which would meet the require-  
23 ments of clause (ii) of such section if that clause were ap-  
24 plied by taking into account the percentage of care pro-

1 vided by the hospital to patients eligible for medical assist-  
2 ance under a State plan under this title”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to drugs purchased on or after  
5 the date of the enactment of this Act.

6 **CHAPTER 2—LONG-TERM CARE UNDER**  
7 **MEDICAID**

8 **Subchapter A—Reform of Asset Transfer**  
9 **Rules**

10 **SEC. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN**  
11 **BEGINNING DATE FOR PERIOD OF INELIGI-**  
12 **BILITY.**

13 (a) LENGTHENING LOOK-BACK PERIOD FOR ALL  
14 DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the  
15 Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is  
16 amended by inserting “or in the case of any other disposal  
17 of assets made on or after the date of the enactment of  
18 the Deficit Reduction Act of 2005” before “, 60 months”.

19 (b) CHANGE IN BEGINNING DATE FOR PERIOD OF  
20 INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42  
21 U.S.C. 1396p(c)(1)(D)) is amended—

22 (1) by striking “(D) The date” and inserting  
23 “(D)(i) In the case of a transfer of asset made be-  
24 fore the date of the enactment of the Deficit Reduc-  
25 tion Act of 2005, the date”; and

1           (2) by adding at the end the following new  
2       clause:

3       “(ii) In the case of a transfer of asset made on or  
4 after the date of the enactment of the Deficit Reduction  
5 Act of 2005, the date specified in this subparagraph is  
6 the first day of a month during or after which assets have  
7 been transferred for less than fair market value, or the  
8 date on which the individual is eligible for medical assist-  
9 ance under the State plan and would otherwise be receiv-  
10 ing institutional level care described in subparagraph (C)  
11 based on an approved application for such care but for  
12 the application of the penalty period, whichever is later,  
13 and which does not occur during any other period of ineli-  
14 gibility under this subsection.”.

15       (c) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to transfers made on or after the  
17 date of the enactment of this Act.

18       (d) AVAILABILITY OF HARDSHIP WAIVERS.—Each  
19 State shall provide for a hardship waiver process in ac-  
20 cordance with section 1917(c)(2)(D) of the Social Security  
21 Act (42 U.S.C. 1396p(c)(2)(D))—

22           (1) under which an undue hardship exists when  
23       application of the transfer of assets provision would  
24       deprive the individual—

1 (A) of medical care such that the individ-  
2 ual's health or life would be endangered; or

3 (B) of food, clothing, shelter, or other ne-  
4 cessities of life; and

5 (2) which provides for—

6 (A) notice to recipients that an undue  
7 hardship exception exists;

8 (B) a timely process for determining  
9 whether an undue hardship waiver will be  
10 granted; and

11 (C) a process under which an adverse de-  
12 termination can be appealed.

13 (e) ADDITIONAL PROVISIONS ON HARDSHIP WAIV-  
14 ERS.—

15 (1) APPLICATION BY FACILITY.—Section  
16 1917(c)(2) of the Social Security Act (42 U.S.C.  
17 1396p(c)(2)) is amended—

18 (A) by striking the semicolon at the end of  
19 subparagraph (D) and inserting a period; and

20 (B) by adding after and below such sub-  
21 paragraph the following:

22 “The procedures established under subparagraph  
23 (D) shall permit the facility in which the institu-  
24 tionalized individual is residing to file an undue  
25 hardship waiver application on behalf of the indi-

1       vidual with the consent of the individual or the per-  
2       sonal representative of the individual.”.

3               (2) AUTHORITY TO MAKE BED HOLD PAYMENTS  
4       FOR HARDSHIP APPLICANTS.—Such section is fur-  
5       ther amended by adding at the end the following:  
6       “While an application for an undue hardship waiver  
7       is pending under subparagraph (D) in the case of an  
8       individual who is a resident of a nursing facility, if  
9       the application meets such criteria as the Secretary  
10      specifies, the State may provide for payments for  
11      nursing facility services in order to hold the bed for  
12      the individual at the facility, but not in excess of  
13      payments for 30 days.”.

14   **SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.**

15       (a) IN GENERAL.—Section 1917 of the Social Secu-  
16      rity Act (42 U.S.C. 1396p) is amended by redesignating  
17      subsection (e) as subsection (f) and by inserting after sub-  
18      section (d) the following new subsection:

19       “(e)(1) In order to meet the requirements of this sec-  
20      tion for purposes of section 1902(a)(18), a State shall re-  
21      quire, as a condition for the provision of medical assist-  
22      ance for services described in subsection (c)(1)(C)(i) (re-  
23      lating to long-term care services) for an individual, the ap-  
24      plication of the individual for such assistance (including  
25      any recertification of eligibility for such assistance) shall

1 disclose a description of any interest the individual or com-  
2 munity spouse has in an annuity (or similar financial in-  
3 strument, as may be specified by the Secretary), regard-  
4 less of whether the annuity is irrevocable or is treated as  
5 an asset. Such application or recertification form shall in-  
6 clude a statement that under paragraph (2) the State be-  
7 comes a remainder beneficiary under such an annuity or  
8 similar financial instrument by virtue of the provision of  
9 such medical assistance.

10 “(2)(A) In the case of disclosure concerning an annu-  
11 ity under subsection (c)(1)(F), the State shall notify the  
12 issuer of the annuity of the right of the State under such  
13 subsection as a preferred remainder beneficiary in the an-  
14 nuity for medical assistance furnished to the individual.  
15 Nothing in this paragraph shall be construed as pre-  
16 venting such an issuer from notifying persons with any  
17 other remainder interest of the State’s remainder interest  
18 under such subsection.

19 “(B) In the case of such an issuer receiving notice  
20 under subparagraph (A), the State may require the issuer  
21 to notify the State when there is a change in the amount  
22 of income or principal being withdrawn from the amount  
23 that was being withdrawn at the time of the most recent  
24 disclosure described in paragraph (1). A State shall take  
25 such information into account in determining the amount



1 of the State's obligations for medical assistance or in the  
2 individual's eligibility for such assistance.

3 “(3) The Secretary may provide guidance to States  
4 on categories of transactions that may be treated as a  
5 transfer of asset for less than fair market value.

6 “(4) Nothing in this subsection shall be construed as  
7 preventing a State from denying eligibility for medical as-  
8 sistance for an individual based on the income or resources  
9 derived from an annuity described in paragraph (1).”.

10 (b) REQUIREMENT FOR STATE TO BE NAMED AS A  
11 REMAINDER BENEFICIARY.—Section 1917(c)(1) of such  
12 Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the  
13 end the following:

14 “(F) For purposes of this paragraph, the purchase  
15 of an annuity shall be treated as the disposal of an asset  
16 for less than fair market value unless—

17 “(i) the State is named as the remainder bene-  
18 ficiary in the first position for at least the total  
19 amount of medical assistance paid on behalf of the  
20 annuitant under this title; or

21 “(ii) the State is named as such a beneficiary  
22 in the second position after the community spouse or  
23 minor or disabled child and is named in the first po-  
24 sition if such spouse or a representative of such

1 child disposes of any such remainder for less than  
2 fair market value.”.

3 (c) INCLUSION OF TRANSFERS TO PURCHASE BAL-  
4 LOON ANNUITIES.—Section 1917(c)(1) of such Act (42  
5 U.S.C. 1396p(c)(1)), as amended by subsection (b), is  
6 amended by adding at the end the following:

7 “(G) For purposes of this paragraph with respect to  
8 a transfer of assets, the term ‘assets’ includes an annuity  
9 purchased by or on behalf of an annuitant who has applied  
10 for medical assistance with respect to nursing facility serv-  
11 ices or other long-term care services under this title  
12 unless—

13 “(i) the annuity is—

14 “(I) an annuity described in subsection (b)  
15 or (q) of section 408 of the Internal Revenue  
16 Code of 1986; or

17 “(II) purchased with proceeds from—

18 “(aa) an account or trust described in  
19 subsection (a), (c), (p) of section 408 of  
20 such Code;

21 “(bb) a simplified employee pension  
22 (within the meaning of section 408(k) of  
23 such Code); or

24 “(cc) a Roth IRA described in section  
25 408A of such Code; or

1 “(ii) the annuity—

2 “(I) is irrevocable and nonassignable;

3 “(II) is actuarially sound (as determined in  
4 accordance with actuarial publications of the  
5 Office of the Chief Actuary of the Social Secu-  
6 rity Administration); and

7 “(III) provides for payments in equal  
8 amounts during the term of the annuity, with  
9 no deferral and no balloon payments made.”.

10 (d) EFFECTIVE DATE.—The amendments made by  
11 this section shall apply to transactions (including the pur-  
12 chase of an annuity) occurring on or after the date of the  
13 enactment of this Act.

14 **SEC. 6013. APPLICATION OF “INCOME-FIRST” RULE IN AP-**  
15 **PLYING COMMUNITY SPOUSE’S INCOME BE-**  
16 **FORE ASSETS IN PROVIDING SUPPORT OF**  
17 **COMMUNITY SPOUSE.**

18 (a) IN GENERAL.—Section 1924(d) of the Social Se-  
19 curity Act (42 U.S.C. 1396r–5(d)) is amended by adding  
20 at the end the following new subparagraph:

21 “(6) APPLICATION OF ‘INCOME FIRST’ RULE TO  
22 REVISION OF COMMUNITY SPOUSE RESOURCE AL-  
23 LOWANCE.—For purposes of this subsection and  
24 subsections (c) and (e), a State must consider that  
25 all income of the institutionalized spouse that could

1 be made available to a community spouse, in accord-  
2 ance with the calculation of the community spouse  
3 monthly income allowance under this subsection, has  
4 been made available before the State allocates to the  
5 community spouse an amount of resources adequate  
6 to provide the difference between the minimum  
7 monthly maintenance needs allowance and all income  
8 available to the community spouse.”.

9 (b) EFFECTIVE DATE.—The amendment made by  
10 subsection (a) shall apply to transfers and allocations  
11 made on or after the date of the enactment of this Act  
12 by individuals who become institutionalized spouses on or  
13 after such date.

14 **SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE AS-**  
15 **SISTANCE FOR INDIVIDUALS WITH SUBSTAN-**  
16 **TIAL HOME EQUITY.**

17 (a) IN GENERAL.—Section 1917 of the Social Secu-  
18 rity Act, as amended by section 6012(a), is further amend-  
19 ed by redesignating subsection (f) as subsection (g) and  
20 by inserting after subsection (e) the following new sub-  
21 section:

22 “(f)(1)(A) Notwithstanding any other provision of  
23 this title, subject to subparagraphs (B) and (C) of this  
24 paragraph and paragraph (2), in determining eligibility of  
25 an individual for medical assistance with respect to nurs-

1 ing facility services or other long-term care services, the  
2 individual shall not be eligible for such assistance if the  
3 individual's equity interest in the individual's home ex-  
4 ceeds \$500,000.

5 “(B) A State may elect, without regard to the re-  
6 quirements of section 1902(a)(1) (relating to  
7 statewideness) and section 1902(a)(10)(B) (relating to  
8 comparability), to apply subparagraph (A) by substituting  
9 for ‘\$500,000’, an amount that exceeds such amount, but  
10 does not exceed \$750,000.

11 “(C) The dollar amounts specified in this paragraph  
12 shall be increased, beginning with 2011, from year to year  
13 based on the percentage increase in the consumer price  
14 index for all urban consumers (all items; United States  
15 city average), rounded to the nearest \$1,000.

16 “(2) Paragraph (1) shall not apply with respect to  
17 an individual if—

18 “(A) the spouse of such individual, or

19 “(B) such individual's child who is under age  
20 21, or (with respect to States eligible to participate  
21 in the State program established under title XVI) is  
22 blind or permanently and totally disabled, or (with  
23 respect to States which are not eligible to participate  
24 in such program) is blind or disabled as defined in  
25 section 1614,

1 is lawfully residing in the individual's home.

2 “(3) Nothing in this subsection shall be construed as  
3 preventing an individual from using a reverse mortgage  
4 or home equity loan to reduce the individual's total equity  
5 interest in the home.

6 “(4) The Secretary shall establish a process whereby  
7 paragraph (1) is waived in the case of a demonstrated  
8 hardship.”.

9 (b) EFFECTIVE DATE.—The amendment made by  
10 subsection (a) shall apply to individuals who are deter-  
11 mined eligible for medical assistance with respect to nurs-  
12 ing facility services or other long-term care services based  
13 on an application filed on or after January 1, 2006.

14 **SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RE-**  
15 **TIREMENT COMMUNITIES (CCRC) AND LIFE**  
16 **CARE COMMUNITY ADMISSION CONTRACTS.**

17 (a) ADMISSION POLICIES OF NURSING FACILITIES.—  
18 Section 1919(c)(5) of the Social Security Act (42 U.S.C.  
19 1396r(c)(5)) is amended—

20 (1) in subparagraph (A)(i)(II), by inserting  
21 “subject to clause (v),” after “(II)”; and

22 (2) by adding at the end of subparagraph (B)  
23 the following new clause:

24 “(v) TREATMENT OF CONTINUING  
25 CARE RETIREMENT COMMUNITIES ADMIS-

1                   SION CONTRACTS.—Notwithstanding sub-  
2                   clause (II) of subparagraph (A)(i), subject  
3                   to subsections (c) and (d) of section 1924,  
4                   contracts for admission to a State licensed,  
5                   registered, certified, or equivalent con-  
6                   tinuing care retirement community or life  
7                   care community, including services in a  
8                   nursing facility that is part of such com-  
9                   munity, may require residents to spend on  
10                  their care resources declared for the pur-  
11                  poses of admission before applying for  
12                  medical assistance.”.

13           (b) TREATMENT OF ENTRANCE FEES.—Section  
14 1917 of such Act (42 U.S.C. 1396p), as amended by sec-  
15 tions 6012(a) and 6014(a), is amended by redesignating  
16 subsection (g) as subsection (h) and by inserting after  
17 subsection (f) the following new subsection:

18           “(g) TREATMENT OF ENTRANCE FEES OF INDIVID-  
19 UALS RESIDING IN CONTINUING CARE RETIREMENT  
20 COMMUNITIES.—

21                   “(1) IN GENERAL.—For purposes of deter-  
22                   mining an individual’s eligibility for, or amount of,  
23                   benefits under a State plan under this title, the rules  
24                   specified in paragraph (2) shall apply to individuals  
25                   residing in continuing care retirement communities

1 or life care communities that collect an entrance fee  
2 on admission from such individuals.

3 “(2) TREATMENT OF ENTRANCE FEE.—For  
4 purposes of this subsection, an individual’s entrance  
5 fee in a continuing care retirement community or  
6 life care community shall be considered a resource  
7 available to the individual to the extent that—

8 “(A) the individual has the ability to use  
9 the entrance fee, or the contract provides that  
10 the entrance fee may be used, to pay for care  
11 should other resources or income of the indi-  
12 vidual be insufficient to pay for such care;

13 “(B) the individual is eligible for a refund  
14 of any remaining entrance fee when the indi-  
15 vidual dies or terminates the continuing care re-  
16 tirement community or life care community  
17 contract and leaves the community; and

18 “(C) the entrance fee does not confer an  
19 ownership interest in the continuing care retire-  
20 ment community or life care community.”.

21 **SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET**  
22 **TRANSFER RULES.**

23 (a) REQUIREMENT TO IMPOSE PARTIAL MONTHS OF  
24 INELIGIBILITY.—Section 1917(c)(1)(E) of the Social Se-



1   curity Act (42 U.S.C. 1396p(c)(1)(E)) is amended by add-  
2   ing at the end the following:

3       “(iv) A State shall not round down, or otherwise dis-  
4   regard any fractional period of ineligibility determined  
5   under clause (i) or (ii) with respect to the disposal of as-  
6   sets.”.

7       (b) AUTHORITY FOR STATES TO ACCUMULATE MUL-  
8   TIPLE TRANSFERS INTO ONE PENALTY PERIOD.—Sec-  
9   tion 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as  
10   amended by subsections (b) and (c) of section 6012, is  
11   amended by adding at the end the following:

12       “(H) Notwithstanding the preceding provisions of  
13   this paragraph, in the case of an individual (or individual’s  
14   spouse) who makes multiple fractional transfers of assets  
15   in more than 1 month for less than fair market value on  
16   or after the applicable look-back date specified in subpara-  
17   graph (B), a State may determine the period of ineligi-  
18   bility applicable to such individual under this paragraph  
19   by—

20           “(i) treating the total, cumulative uncompen-  
21   sated value of all assets transferred by the individual  
22   (or individual’s spouse) during all months on or  
23   after the look-back date specified in subparagraph  
24   (B) as 1 transfer for purposes of clause (i) or (ii)  
25   (as the case may be) of subparagraph (E); and

1           “(ii) beginning such period on the earliest date  
2           which would apply under subparagraph (D) to any  
3           of such transfers.”.

4           (c) INCLUSION OF TRANSFER OF CERTAIN NOTES  
5   AND LOANS ASSETS.—Section 1917(c)(1) of such Act (42  
6   U.S.C. 1396 p(c)(1)), as amended by subsection (b), is  
7   amended by adding at the end the following:

8           “(I) For purposes of this paragraph with respect to  
9   a transfer of assets, the term ‘assets’ includes funds used  
10   to purchase a promissory note, loan, or mortgage unless  
11   such note, loan, or mortgage—

12           “(i) has a repayment term that is actuarially  
13           sound (as determined in accordance with actuarial  
14           publications of the Office of the Chief Actuary of the  
15           Social Security Administration);

16           “(ii) provides for payments to be made in equal  
17           amounts during the term of the loan, with no defer-  
18           ral and no balloon payments made; and

19           “(iii) prohibits the cancellation of the balance  
20           upon the death of the lender.

21   In the case of a promissory note, loan, or mortgage that  
22   does not satisfy the requirements of clauses (i) through  
23   (iii), the value of such note, loan, or mortgage shall be  
24   the outstanding balance due as of the date of the individ-

1   ual's application for medical assistance for services de-  
2   scribed in subparagraph (C).”.

3       (d) INCLUSION OF TRANSFERS TO PURCHASE LIFE  
4   ESTATES.—Section 1917(c)(1) of such Act (42 U.S.C.  
5   1396p(c)(1)), as amended by subsection (c), is amended  
6   by adding at the end the following:

7       “(J) For purposes of this paragraph with respect to  
8   a transfer of assets, the term ‘assets’ includes the pur-  
9   chase of a life estate interest in another individual's home  
10   unless the purchaser resides in the home for a period of  
11   at least 1 year after the date of the purchase.”.

12       (e) EFFECTIVE DATES.—

13           (1) IN GENERAL.—Except as provided in para-  
14   graphs (2) and (3), the amendments made by this  
15   section shall apply to payments under title XIX of  
16   the Social Security Act (42 U.S.C. 1396 et seq.) for  
17   calendar quarters beginning on or after the date of  
18   enactment of this Act, without regard to whether or  
19   not final regulations to carry out such amendments  
20   have been promulgated by such date.

21           (2) EXCEPTIONS.—The amendments made by  
22   this section shall not apply—

23               (A) to medical assistance provided for serv-  
24   ices furnished before the date of enactment;

1 (B) with respect to assets disposed of on  
2 or before the date of enactment of this Act; or

3 (C) with respect to trusts established on or  
4 before the date of enactment of this Act.

5 (3) EXTENSION OF EFFECTIVE DATE FOR  
6 STATE LAW AMENDMENT.—In the case of a State  
7 plan under title XIX of the Social Security Act (42  
8 U.S.C. 1396 et seq.) which the Secretary of Health  
9 and Human Services determines requires State legis-  
10 lation in order for the plan to meet the additional  
11 requirements imposed by the amendments made by  
12 a provision of this section, the State plan shall not  
13 be regarded as failing to comply with the require-  
14 ments of such title solely on the basis of its failure  
15 to meet these additional requirements before the  
16 first day of the first calendar quarter beginning  
17 after the close of the first regular session of the  
18 State legislature that begins after the date of the en-  
19 actment of this Act. For purposes of the previous  
20 sentence, in the case of a State that has a 2-year  
21 legislative session, each year of the session is consid-  
22 ered to be a separate regular session of the State  
23 legislature.

1     **Subchapter B—Expanded Access to Certain**  
2                     **Benefits**

3     **SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PART-**  
4                     **NERSHIP PROGRAM.**

5         (a) EXPANSION AUTHORITY.—

6             (1) IN GENERAL.—Section 1917(b) of the So-  
7         cial Security Act (42 U.S.C. 1396p(b)) is  
8         amended—

9             (A) in paragraph (1)(C)—

10                 (i) in clause (ii), by inserting “and  
11                 which satisfies clause (iv), or which has a  
12                 State plan amendment that provides for a  
13                 qualified State long-term care insurance  
14                 partnership (as defined in clause (iii))”  
15                 after “1993,”; and

16                 (ii) by adding at the end the following  
17                 new clauses:

18                 “(iii) For purposes of this paragraph, the term  
19                 ‘qualified State long-term care insurance partner-  
20                 ship’ means an approved State plan amendment  
21                 under this title that provides for the disregard of  
22                 any assets or resources in an amount equal to the  
23                 insurance benefit payments that are made to or on  
24                 behalf of an individual who is a beneficiary under a

1 long-term care insurance policy if the following re-  
2 quirements are met:

3 “(I) The policy covers an insured who was  
4 a resident of such State when coverage first be-  
5 came effective under the policy.

6 “(II) The policy is a qualified long-term  
7 care insurance policy (as defined in section  
8 7702B(b) of the Internal Revenue Code of  
9 1986) issued not earlier than the effective date  
10 of the State plan amendment.

11 “(III) The policy meets the model regula-  
12 tions and the requirements of the model Act  
13 specified in paragraph (5).

14 “(IV) If the policy is sold to an individual  
15 who—

16 “(aa) has not attained age 61 as of  
17 the date of purchase, the policy provides  
18 compound annual inflation protection;

19 “(bb) has attained age 61 but has not  
20 attained age 76 as of such date, the policy  
21 provides some level of inflation protection;  
22 and

23 “(cc) has attained age 76 as of such  
24 date, the policy may (but is not required

1           to) provide some level of inflation protec-  
2           tion.

3           “(V) The State Medicaid agency under sec-  
4           tion 1902(a)(5) provides information and tech-  
5           nical assistance to the State insurance depart-  
6           ment on the insurance department’s role of as-  
7           suring that any individual who sells a long-term  
8           care insurance policy under the partnership re-  
9           ceives training and demonstrates evidence of an  
10          understanding of such policies and how they re-  
11          late to other public and private coverage of  
12          long-term care.

13          “(VI) The issuer of the policy provides reg-  
14          ular reports to the Secretary, in accordance  
15          with regulations of the Secretary, that include  
16          notification regarding when benefits provided  
17          under the policy have been paid and the amount  
18          of such benefits paid, notification regarding  
19          when the policy otherwise terminates, and such  
20          other information as the Secretary determines  
21          may be appropriate to the administration of  
22          such partnerships.

23          “(VII) The State does not impose any re-  
24          quirement affecting the terms or benefits of  
25          such a policy unless the State imposes such re-

1           quirement on long-term care insurance policies  
2           without regard to whether the policy is covered  
3           under the partnership or is offered in connec-  
4           tion with such a partnership.

5       In the case of a long-term care insurance policy  
6       which is exchanged for another such policy, sub-  
7       clause (I) shall be applied based on the coverage of  
8       the first such policy that was exchanged. For pur-  
9       poses of this clause and paragraph (5), the term  
10      ‘long-term care insurance policy’ includes a certifi-  
11      cate issued under a group insurance contract

12           “(iv) With respect to a State which had a State  
13      plan amendment approved as of May 14, 1993, such  
14      a State satisfies this clause for purposes of clause  
15      (ii) if the Secretary determines that the State plan  
16      amendment provides for consumer protection stand-  
17      ards which are no less stringent than the consumer  
18      protection standards which applied under such State  
19      plan amendment as of December 31, 2005.

20           “(v) The regulations of the Secretary required  
21      under clause (iii)(VI) shall be promulgated after  
22      consultation with the National Association of Insur-  
23      ance Commissioners, issuers of long-term care insur-  
24      ance policies, States with experience with long-term  
25      care insurance partnership plans, other States, and



1       representatives of consumers of long-term care in-  
2       surance policies, and shall specify the type and for-  
3       mat of the data and information to be reported and  
4       the frequency with which such reports are to be  
5       made. The Secretary, as appropriate, shall provide  
6       copies of the reports provided in accordance with  
7       that clause to the State involved.

8               “(vi) The Secretary, in consultation with other  
9       appropriate Federal agencies, issuers of long-term  
10      care insurance, the National Association of Insur-  
11      ance Commissioners, State insurance commissioners,  
12      States with experience with long-term care insurance  
13      partnership plans, other States, and representatives  
14      of consumers of long-term care insurance policies,  
15      shall develop recommendations for Congress to au-  
16      thorize and fund a uniform minimum data set to be  
17      reported electronically by all issuers of long-term  
18      care insurance policies under qualified State long-  
19      term care insurance partnerships to a secure, cen-  
20      tralized electronic query and report-generating  
21      mechanism that the State, the Secretary, and other  
22      Federal agencies can access.”; and

23               (B) by adding at the end the following:

1       “(5)(A) For purposes of clause (iii)(III), the model  
2 regulations and the requirements of the model Act speci-  
3 fied in this paragraph are:

4               “(i) In the case of the model regulation, the fol-  
5 lowing requirements:

6                       “(I) Section 6A (relating to guaranteed re-  
7 newal or noncancellability), other than para-  
8 graph (5) thereof, and the requirements of sec-  
9 tion 6B of the model Act relating to such sec-  
10 tion 6A.

11                      “(II) Section 6B (relating to prohibitions  
12 on limitations and exclusions) other than para-  
13 graph (7) thereof.

14                      “(III) Section 6C (relating to extension of  
15 benefits).

16                      “(IV) Section 6D (relating to continuation  
17 or conversion of coverage).

18                      “(V) Section 6E (relating to discontinu-  
19 ance and replacement of policies).

20                      “(VI) Section 7 (relating to unintentional  
21 lapse).

22                      “(VII) Section 8 (relating to disclosure),  
23 other than sections 8F, 8G, 8H, and 8I thereof.

24                      “(VIII) Section 9 (relating to required dis-  
25 closure of rating practices to consumer).

1           “(IX) Section 11 (relating to prohibitions  
2           against post-claims underwriting).

3           “(X) Section 12 (relating to minimum  
4           standards).

5           “(XI) Section 14 (relating to application  
6           forms and replacement coverage).

7           “(XII) Section 15 (relating to reporting re-  
8           quirements).

9           “(XIII) Section 22 (relating to filing re-  
10          quirements for marketing).

11          “(XIV) Section 23 (relating to standards  
12          for marketing), including inaccurate completion  
13          of medical histories, other than paragraphs (1),  
14          (6), and (9) of section 23C.

15          “(XV) Section 24 (relating to suitability).

16          “(XVI) Section 25 (relating to prohibition  
17          against preexisting conditions and probationary  
18          periods in replacement policies or certificates).

19          “(XVII) The provisions of section 26 relat-  
20          ing to contingent nonforfeiture benefits, if the  
21          policyholder declines the offer of a nonforfeiture  
22          provision described in paragraph (4).

23          “(XVIII) Section 29 (relating to standard  
24          format outline of coverage).

1           “(XIX) Section 30 (relating to require-  
2           ment to deliver shopper’s guide).

3           “(ii) In the case of the model Act, the following:

4           “(I) Section 6C (relating to preexisting  
5           conditions).

6           “(II) Section 6D (relating to prior hos-  
7           pitalization).

8           “(III) The provisions of section 8 relating  
9           to contingent nonforfeiture benefits.

10           “(IV) Section 6F (relating to right to re-  
11           turn).

12           “(V) Section 6G (relating to outline of cov-  
13           erage).

14           “(VI) Section 6H (relating to requirements  
15           for certificates under group plans).

16           “(VII) Section 6J (relating to policy sum-  
17           mary).

18           “(VIII) Section 6K (relating to monthly  
19           reports on accelerated death benefits).

20           “(IX) Section 7 (relating to incontest-  
21           ability period).

22           “(B) For purposes of this paragraph and paragraph  
23           (1)(C)—

24           “(i) the terms ‘model regulation’ and ‘model  
25           Act’ mean the long-term care insurance model regu-

1       lation, and the long-term care insurance model Act,  
2       respectively, promulgated by the National Associa-  
3       tion of Insurance Commissioners (as adopted as of  
4       October 2000);

5           “(ii) any provision of the model regulation or  
6       model Act listed under subparagraph (A) shall be  
7       treated as including any other provision of such reg-  
8       ulation or Act necessary to implement the provision;  
9       and

10          “(iii) with respect to a long-term care insurance  
11       policy issued in a State, the policy shall be deemed  
12       to meet applicable requirements of the model regula-  
13       tion or the model Act if the State plan amendment  
14       under paragraph (1)(C)(iii) provides that the State  
15       insurance commissioner for the State certifies (in a  
16       manner satisfactory to the Secretary) that the policy  
17       meets such requirements.

18          “(C) Not later than 12 months after the National As-  
19       sociation of Insurance Commissioners issues a revision,  
20       update, or other modification of a model regulation or  
21       model Act provision specified in subparagraph (A), or of  
22       any provision of such regulation or Act that is sub-  
23       stantively related to a provision specified in such subpara-  
24       graph, the Secretary shall review the changes made to the  
25       provision, determine whether incorporating such changes

1 into the corresponding provision specified in such subpara-  
2 graph would improve qualified State long-term care insur-  
3 ance partnerships, and if so, shall incorporate the changes  
4 into such provision.”.

5 (2) STATE REPORTING REQUIREMENTS.—Noth-  
6 ing in clauses (iii)(VI) and (v) of section  
7 1917(b)(1)(C) of the Social Security Act (as added  
8 by paragraph (1)) shall be construed as prohibiting  
9 a State from requiring an issuer of a long-term care  
10 insurance policy sold in the State (regardless of  
11 whether the policy is issued under a qualified State  
12 long-term care insurance partnership under section  
13 1917(b)(1)(C)(iii) of such Act) to require the issuer  
14 to report information or data to the State that is in  
15 addition to the information or data required under  
16 such clauses.

17 (3) EFFECTIVE DATE.—A State plan amend-  
18 ment that provides for a qualified State long-term  
19 care insurance partnership under the amendments  
20 made by paragraph (1) may provide that such  
21 amendment is effective for long-term care insurance  
22 policies issued on or after a date, specified in the  
23 amendment, that is not earlier than the first day of  
24 the first calendar quarter in which the plan amend-

1       ment was submitted to the Secretary of Health and  
2       Human Services.

3       (b) STANDARDS FOR RECIPROCAL RECOGNITION  
4       AMONG PARTNERSHIP STATES.—In order to permit port-  
5       ability in long-term care insurance policies purchased  
6       under State long-term care insurance partnerships, the  
7       Secretary of Health and Human Services shall develop,  
8       not later than January 1, 2007, and in consultation with  
9       the National Association of Insurance Commissioners,  
10      issuers of long-term care insurance policies, States with  
11      experience with long-term care insurance partnership  
12      plans, other States, and representatives of consumers of  
13      long-term care insurance policies, standards for uniform  
14      reciprocal recognition of such policies among States with  
15      qualified State long-term care insurance partnerships  
16      under which—

17           (1) benefits paid under such policies will be  
18      treated the same by all such States; and

19           (2) States with such partnerships shall be sub-  
20      ject to such standards unless the State notifies the  
21      Secretary in writing of the State's election to be ex-  
22      empt from such standards.

23      (c) ANNUAL REPORTS TO CONGRESS.—

24           (1) IN GENERAL.—The Secretary of Health and  
25      Human Services shall annually report to Congress

1 on the long-term care insurance partnerships estab-  
2 lished in accordance with section 1917(b)(1)(C)(ii)  
3 of the Social Security Act (42 U.S.C.  
4 1396p(b)(1)(C)(ii)) (as amended by subsection  
5 (a)(1)). Such reports shall include analyses of the  
6 extent to which such partnerships expand or limit  
7 access of individuals to long-term care and the im-  
8 pact of such partnerships on Federal and State ex-  
9 penditures under the Medicare and Medicaid pro-  
10 grams. Nothing in this section shall be construed as  
11 requiring the Secretary to conduct an independent  
12 review of each long-term care insurance policy of-  
13 fered under or in connection with such a partner-  
14 ship.

15 (2) APPROPRIATION.—Out of any funds in the  
16 Treasury not otherwise appropriated, there is appro-  
17 priated to the Secretary of Health and Human Serv-  
18 ices, \$1,000,000 for the period of fiscal years 2006  
19 through 2010 to carry out paragraph (1).

20 (d) NATIONAL CLEARINGHOUSE FOR LONG-TERM  
21 CARE INFORMATION.—

22 (1) ESTABLISHMENT.—The Secretary of Health  
23 and Human Services shall establish a National  
24 Clearinghouse for Long-Term Care Information. The



1 Clearinghouse may be established through a contract  
2 or interagency agreement.

3 (2) DUTIES.—

4 (A) IN GENERAL.—The National Clearing-  
5 house for Long-Term Care Information shall—

6 (i) educate consumers with respect to  
7 the availability and limitations of coverage  
8 for long-term care under the Medicaid pro-  
9 gram and provide contact information for  
10 obtaining State-specific information on  
11 long-term care coverage, including eligi-  
12 bility and estate recovery requirements  
13 under State Medicaid programs;

14 (ii) provide objective information to  
15 assist consumers with the decisionmaking  
16 process for determining whether to pur-  
17 chase long-term care insurance or to pur-  
18 sue other private market alternatives for  
19 purchasing long-term care and provide con-  
20 tact information for additional objective re-  
21 sources on planning for long-term care  
22 needs; and

23 (iii) maintain a list of States with  
24 State long-term care insurance partner-  
25 ships under the Medicaid program that

1 provide reciprocal recognition of long-term  
2 care insurance policies issued under such  
3 partnerships.

4 (B) REQUIREMENT.—In providing infor-  
5 mation to consumers on long-term care in ac-  
6 cordance with this subsection, the National  
7 Clearinghouse for Long-Term Care Information  
8 shall not advocate in favor of a specific long-  
9 term care insurance provider or a specific long-  
10 term care insurance policy.

11 (3) APPROPRIATION.—Out of any funds in the  
12 Treasury not otherwise appropriated, there is appro-  
13 priated to carry out this subsection, \$3,000,000 for  
14 each of fiscal years 2006 through 2010.

15 **CHAPTER 3—ELIMINATING FRAUD,**  
16 **WASTE, AND ABUSE IN MEDICAID**

17 **SEC. 6031. LIMITATION ON USE OF CONTINGENCY FEE AR-**  
18 **RANGEMENTS.**

19 (a) IN GENERAL.—Section 1903(i) of the Social Se-  
20 curity Act (42 U.S.C. 1396b(i)), as amended by section  
21 104(b) of Public Law 109–91, is amended—

22 (1) in paragraph (20), by adding “or” at the  
23 end;

24 (2) by striking the period at the end of para-  
25 graph (21) and inserting “; or”; and

1           (3) by inserting after paragraph (21), the fol-  
2       lowing:

3           “(22) with respect to any amount expended in  
4       connection with a contract or agreement (other than  
5       a risk contract under section 1903(m)) between the  
6       State agency under section 1902(a)(5) (or any State  
7       or local agency designated by such agency to admin-  
8       ister any portion of the State plan under this title)  
9       and a consultant or other contractor if the terms of  
10      compensation for the consultant or other contractor  
11      do not meet the standards established by the Sec-  
12      retary of Health and Human Services under section  
13      6031(b) of the Deficit Reduction Act of 2005.”.

14      (b) CONTINGENCY FEE ARRANGEMENT STAND-  
15      ARDS.—Not later than 6 months after the date of enact-  
16      ment of this Act, the Secretary of Health and Human  
17      Services shall issue standards for the terms of compensa-  
18      tion of consultants and other individuals or entities con-  
19      tracting with State agencies (or their designees) admin-  
20      istering State Medicaid plans under title XIX of the Social  
21      Security Act that ensure prudent purchasing and program  
22      integrity with respect to Federal funds. The Secretary of  
23      Health and Human Services shall review and revise, as  
24      necessary, such standards to promptly address new com-

1   pensation arrangements that may present a risk to pro-  
2   gram integrity under such title.

3       (c) APPROPRIATION.—Out of any funds in the Treas-  
4   ury not otherwise appropriated, there is appropriated to  
5   the Secretary of Health and Human Services, \$550,000  
6   for fiscal year 2006 to carry out the amendment made  
7   by subsection (a) and subsection (b).

8       (d) EFFECTIVE DATE.—Except as provided in sec-  
9   tion 6035(e), the amendments made by subsection (a) take  
10  effect on January 1, 2007.

11 **SEC. 6032. ENCOURAGING THE ENACTMENT OF STATE**  
12 **FALSE CLAIMS ACTS.**

13       (a) IN GENERAL.—Title XIX of the Social Security  
14  Act (42 U.S.C. 1396 et seq.) is amended by inserting after  
15  section 1908A the following:

16       “STATE FALSE CLAIMS ACT REQUIREMENTS FOR  
17       INCREASED STATE SHARE OF RECOVERIES

18       “SEC. 1909. (a) IN GENERAL.—Notwithstanding sec-  
19  tion 1905(b), if a State has in effect a law relating to  
20  false or fraudulent claims that meets the requirements of  
21  subsection (b), the Federal medical assistance percentage  
22  with respect to any amounts recovered under a State ac-  
23  tion brought under such law, shall be decreased by 10 per-  
24  centage points.

25       “(b) REQUIREMENTS.—For purposes of subsection  
26  (a), the requirements of this subsection are that the In-

1   spector General of the Department of Health and Human  
2   Services, in consultation with the Attorney General, deter-  
3   mines that the State has in effect a law that meets the  
4   following requirements:

5           “(1) The law establishes liability to the State  
6           for false or fraudulent claims described in section  
7           3729 of title 31, United States Code, with respect  
8           to any expenditure described in section 1903(a).

9           “(2) The law contains provisions that are at  
10          least as effective in rewarding and facilitating qui  
11          tam actions for false or fraudulent claims as those  
12          described in sections 3730 through 3732 of title 31,  
13          United States Code.

14          “(3) The law contains a requirement for filing  
15          an action under seal for 60 days with review by the  
16          State Attorney General.

17          “(4) The law contains a civil penalty that is not  
18          less than the amount of the civil penalty authorized  
19          under section 3729 of title 31, United States Code.

20          “(c) DEEMED COMPLIANCE.—A State that, as of  
21          January 1, 2007, has a law in effect that meets the re-  
22          quirements of subsection (b) shall be deemed to be in com-  
23          pliance with such requirements for so long as the law con-  
24          tinues to meet such requirements.

1       “(d) NO PRECLUSION OF BROADER LAWS.—Nothing  
2 in this section shall be construed as prohibiting a State  
3 that has in effect a law that establishes liability to the  
4 State for false or fraudulent claims described in section  
5 3729 of title 31, United States Code, with respect to pro-  
6 grams in addition to the State program under this title,  
7 or with respect to expenditures in addition to expenditures  
8 described in section 1903(a), from being considered to be  
9 in compliance with the requirements of subsection (a) so  
10 long as the law meets such requirements.”.

11       (b) EFFECTIVE DATE.—Except as provided in sec-  
12 tion 6035(e), the amendments made by this section take  
13 effect on January 1, 2007.

14       **SEC. 6033. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS**  
15                               **RECOVERY.**

16       (a) IN GENERAL.—Section 1902(a) of the Social Se-  
17 curity Act (42 U.S.C. 1396a(a)) is amended—

18               (1) in paragraph (66), by striking “and” at the  
19 end;

20               (2) in paragraph (67) by striking the period at  
21 the end and inserting “; and”; and

22               (3) by inserting after paragraph (67) the fol-  
23 lowing:

24               “(68) provide that any entity that receives or  
25 makes annual payments under the State plan of at

1       least \$5,000,000, as a condition of receiving such  
2       payments, shall—

3               “(A) establish written policies for all em-  
4       ployees of the entity (including management),  
5       and of any contractor or agent of the entity,  
6       that provide detailed information about the  
7       False Claims Act established under sections  
8       3729 through 3733 of title 31, United States  
9       Code, administrative remedies for false claims  
10      and statements established under chapter 38 of  
11      title 31, United States Code, any State laws  
12      pertaining to civil or criminal penalties for false  
13      claims and statements, and whistleblower pro-  
14      tections under such laws, with respect to the  
15      role of such laws in preventing and detecting  
16      fraud, waste, and abuse in Federal health care  
17      programs (as defined in section 1128B(f));

18              “(B) include as part of such written poli-  
19      cies, detailed provisions regarding the entity’s  
20      policies and procedures for detecting and pre-  
21      venting fraud, waste, and abuse; and

22              “(C) include in any employee handbook for  
23      the entity, a specific discussion of the laws de-  
24      scribed in subparagraph (A), the rights of em-  
25      ployees to be protected as whistleblowers, and

1 the entity's policies and procedures for detect-  
2 ing and preventing fraud, waste, and abuse.”.

3 (b) EFFECTIVE DATE.—Except as provided in sec-  
4 tion 6035(e), the amendments made by subsection (a) take  
5 effect on January 1, 2007.

6 **SEC. 6034. PROHIBITION ON RESTOCKING AND DOUBLE**  
7 **BILLING OF PRESCRIPTION DRUGS.**

8 (a) IN GENERAL.—Section 1903(i)(10) of the Social  
9 Security Act (42 U.S.C. 1396b(i)), as amended by section  
10 6002(b), is amended—

11 (1) in subparagraph (B), by striking “and” at  
12 the end;

13 (2) in subparagraph (C), by striking “; or” at  
14 the end and inserting “, and”; and

15 (3) by adding at the end the following:

16 “(D) with respect to any amount expended for  
17 reimbursement to a pharmacy under this title for  
18 the ingredient cost of a covered outpatient drug for  
19 which the pharmacy has already received payment  
20 under this title (other than with respect to a reason-  
21 able restocking fee for such drug); or”.

22 (b) EFFECTIVE DATE.—The amendments made by  
23 subsection (a) take effect on the first day of the first fiscal  
24 year quarter that begins after the date of enactment of  
25 this Act.



1   **SEC. 6035. MEDICAID INTEGRITY PROGRAM.**

2           (a) ESTABLISHMENT OF MEDICAID INTEGRITY PRO-  
3   GRAM.—Title XIX of the Social Security Act (42 U.S.C.  
4   1396 et seq.) is amended—

5           (1) by redesignating section 1936 as section  
6   1937; and

7           (2) by inserting after section 1935 the fol-  
8   lowing:

9           “MEDICAID INTEGRITY PROGRAM

10          “SEC. 1936. (a) IN GENERAL.—There is hereby es-  
11   tablished the Medicaid Integrity Program (in this section  
12   referred to as the ‘Program’) under which the Secretary  
13   shall promote the integrity of the program under this title  
14   by entering into contracts in accordance with this section  
15   with eligible entities to carry out the activities described  
16   in subsection (b).

17          “(b) ACTIVITIES DESCRIBED—Activities described in  
18   this subsection are as follows:

19           “(1) Review of the actions of individuals or en-  
20   tities furnishing items or services (whether on a fee-  
21   for-service, risk, or other basis) for which payment  
22   may be made under a State plan approved under  
23   this title (or under any waiver of such plan approved  
24   under section 1115) to determine whether fraud,  
25   waste, or abuse has occurred, is likely to occur, or  
26   whether such actions have any potential for resulting

1 in an expenditure of funds under this title in a man-  
2 ner which is not intended under the provisions of  
3 this title.

4 “(2) Audit of claims for payment for items or  
5 services furnished, or administrative services ren-  
6 dered, under a State plan under this title,  
7 including—

8 “(A) cost reports;

9 “(B) consulting contracts; and

10 “(C) risk contracts under section 1903(m).

11 “(3) Identification of overpayments to individ-  
12 uals or entities receiving Federal funds under this  
13 title.

14 “(4) Education of providers of services, man-  
15 aged care entities, beneficiaries, and other individ-  
16 uals with respect to payment integrity and quality of  
17 care.

18 “(c) ELIGIBLE ENTITY AND CONTRACTING REQUIRE-  
19 MENTS.—

20 “(1) IN GENERAL.—An entity is eligible to  
21 enter into a contract under the Program to carry  
22 out any of the activities described in subsection (b)  
23 if the entity satisfies the requirements of paragraphs  
24 (2) and (3).

1           “(2) ELIGIBILITY REQUIREMENTS.—The re-  
2           quirements of this paragraph are the following:

3                   “(A) The entity has demonstrated capa-  
4                   bility to carry out the activities described in  
5                   subsection (b).

6                   “(B) In carrying out such activities, the  
7                   entity agrees to cooperate with the Inspector  
8                   General of the Department of Health and  
9                   Human Services, the Attorney General, and  
10                  other law enforcement agencies, as appropriate,  
11                  in the investigation and deterrence of fraud and  
12                  abuse in relation to this title and in other cases  
13                  arising out of such activities.

14                  “(C) The entity complies with such conflict  
15                  of interest standards as are generally applicable  
16                  to Federal acquisition and procurement.

17                  “(D) The entity meets such other require-  
18                  ments as the Secretary may impose.

19           “(3) CONTRACTING REQUIREMENTS.—The enti-  
20           ty has contracted with the Secretary in accordance  
21           with such procedures as the Secretary shall by regu-  
22           lation establish, except that such procedures shall in-  
23           clude the following:

24                   “(A) Procedures for identifying, evalu-  
25                   ating, and resolving organizational conflicts of

1 interest that are generally applicable to Federal  
2 acquisition and procurement.

3 “(B) Competitive procedures to be used—

4 “(i) when entering into new contracts  
5 under this section;

6 “(ii) when entering into contracts that  
7 may result in the elimination of respon-  
8 sibilities under section 202(b) of the  
9 Health Insurance Portability and Account-  
10 ability Act of 1996; and

11 “(iii) at any other time considered ap-  
12 propriate by the Secretary.

13 “(C) Procedures under which a contract  
14 under this section may be renewed without re-  
15 gard to any provision of law requiring competi-  
16 tion if the contractor has met or exceeded the  
17 performance requirements established in the  
18 current contract.

19 The Secretary may enter into such contracts without  
20 regard to final rules having been promulgated.

21 “(4) LIMITATION ON CONTRACTOR LIABIL-  
22 ITY.—The Secretary shall by regulation provide for  
23 the limitation of a contractor’s liability for actions  
24 taken to carry out a contract under the Program,  
25 and such regulation shall, to the extent the Sec-

1       retary finds appropriate, employ the same or com-  
2       parable standards and other substantive and proce-  
3       dural provisions as are contained in section 1157.

4       “(d) COMPREHENSIVE PLAN FOR PROGRAM INTEG-  
5       RITY.—

6               “(1) 5-YEAR PLAN.—With respect to the 5 fis-  
7       cal year period beginning with fiscal year 2006, and  
8       each such 5-fiscal year period that begins thereafter,  
9       the Secretary shall establish a comprehensive plan  
10      for ensuring the integrity of the program established  
11      under this title by combatting fraud, waste, and  
12      abuse.

13             “(2) CONSULTATION.—Each 5-fiscal year plan  
14      established under paragraph (1) shall be developed  
15      by the Secretary in consultation with the Attorney  
16      General, the Director of the Federal Bureau of In-  
17      vestigation, the Comptroller General of the United  
18      States, the Inspector General of the Department of  
19      Health and Human Services, and State officials with  
20      responsibility for controlling provider fraud and  
21      abuse under State plans under this title.

22      “(e) APPROPRIATION.—

23             “(1) IN GENERAL.—Out of any money in the  
24      Treasury of the United States not otherwise appro-  
25      priated, there are appropriated to carry out the

1 Medicaid Integrity Program under this section, with-  
2 out further appropriation—

3 “(A) for fiscal year 2006, \$5,000,000;

4 “(B) for each of fiscal years 2007 and  
5 2008, \$50,000,000; and

6 “(C) for each fiscal year thereafter,  
7 \$75,000,000.

8 “(2) AVAILABILITY.—Amounts appropriated  
9 pursuant to paragraph (1) shall remain available  
10 until expended.

11 “(3) INCREASE IN CMS STAFFING DEVOTED TO  
12 PROTECTING MEDICAID PROGRAM INTEGRITY.—  
13 From the amounts appropriated under paragraph  
14 (1), the Secretary shall increase by 100 the number  
15 of full-time equivalent employees whose duties con-  
16 sist solely of protecting the integrity of the Medicaid  
17 program established under this section by providing  
18 effective support and assistance to States to combat  
19 provider fraud and abuse.

20 “(4) ANNUAL REPORT.—Not later than 180  
21 days after the end of each fiscal year (beginning  
22 with fiscal year 2006), the Secretary shall submit a  
23 report to Congress which identifies—

24 “(A) the use of funds appropriated pursu-  
25 ant to paragraph (1); and

1                   “(B) the effectiveness of the use of such  
2                   funds.”.

3           (b) STATE REQUIREMENT TO COOPERATE WITH IN-  
4 INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such  
5 Act (42 U.S.C. 1396a(a)), as amended by section 6033(a),  
6 is amended—

7           (1) in paragraph (67), by striking “and” at the  
8           end;

9           (2) in paragraph (68), by striking the period at  
10          the end and inserting “; and”; and

11          (3) by inserting after paragraph (68), the fol-  
12          lowing:

13               “(69) provide that the State must comply with  
14               any requirements determined by the Secretary to be  
15               necessary for carrying out the Medicaid Integrity  
16               Program established under section 1936.”.

17          (c) INCREASED FUNDING FOR MEDICAID FRAUD AND  
18 ABUSE CONTROL ACTIVITIES.—

19           (1) IN GENERAL.—Out of any money in the  
20          Treasury of the United States not otherwise appro-  
21          priated, there are appropriated to the Office of the  
22          Inspector General of the Department of Health and  
23          Human Services, without further appropriation,  
24          \$25,000,000 for each of fiscal years 2006 through  
25          2010, for activities of such Office with respect to the

1 Medicaid program under title XIX of the Social Se-  
2 curity Act (42 U.S.C. 1396 et seq.).

3 (2) AVAILABILITY; AMOUNTS IN ADDITION TO  
4 OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVI-  
5 TIES.—Amounts appropriated pursuant to para-  
6 graph (1) shall—

7 (A) remain available until expended; and

8 (B) be in addition to any other amounts  
9 appropriated or made available to the Office of  
10 the Inspector General of the Department of  
11 Health and Human Services for activities of  
12 such Office with respect to the Medicaid pro-  
13 gram.

14 (3) ANNUAL REPORT.—Not later than 180 days  
15 after the end of each fiscal year (beginning with fis-  
16 cal year 2006), the Inspector General of the Depart-  
17 ment of Health and Human Services shall submit a  
18 report to Congress which identifies—

19 (A) the use of funds appropriated pursuant  
20 to paragraph (1); and

21 (B) the effectiveness of the use of such  
22 funds.

23 (d) NATIONAL EXPANSION OF THE MEDICARE-MED-  
24 ICAID (MEDI-MEDI) DATA MATCH PILOT PROGRAM.—



1           (1) REQUIREMENT OF THE MEDICARE INTEG-  
2           RITY PROGRAM.—Section 1893 of the Social Secu-  
3           rity Act (42 U.S.C. 1395ddd) is amended—

4                   (A) in subsection (b), by adding at the end  
5           the following:

6           “(6) The Medicare-Medicaid Data Match Pro-  
7           gram in accordance with subsection (g).”; and

8                   (B) by adding at the end the following:

9           “(g) MEDICARE-MEDICAID DATA MATCH PRO-  
10          GRAM.—

11           “(1) EXPANSION OF PROGRAM.—

12                   “(A) IN GENERAL.—The Secretary shall  
13           enter into contracts with eligible entities for the  
14           purpose of ensuring that, beginning with 2006,  
15           the Medicare-Medicaid Data Match Program  
16           (commonly referred to as the ‘Medi-Medi Pro-  
17           gram’) is conducted with respect to the pro-  
18           gram established under this title and State  
19           Medicaid programs under title XIX for the pur-  
20           pose of—

21                   “(i)           identifying           program  
22           vulnerabilities in the program established  
23           under this title and the Medicaid program  
24           established under title XIX through the  
25           use of computer algorithms to look for

1 payment anomalies (including billing or  
2 billing patterns identified with respect to  
3 service, time, or patient that appear to be  
4 suspect or otherwise implausible);

5 “(ii) working with States, the Attor-  
6 ney General, and the Inspector General of  
7 the Department of Health and Human  
8 Services to coordinate appropriate actions  
9 to protect the Federal and State share of  
10 expenditures under the Medicaid program  
11 under title XIX, as well as the program es-  
12 tablished under this title; and

13 “(iii) increasing the effectiveness and  
14 efficiency of both such programs through  
15 cost avoidance, savings, and recoupments  
16 of fraudulent, wasteful, or abusive expendi-  
17 tures.

18 “(B) REPORTING REQUIREMENTS.—The  
19 Secretary shall make available in a timely man-  
20 ner any data and statistical information col-  
21 lected by the Medi-Medi Program to the Attor-  
22 ney General, the Director of the Federal Bu-  
23 reau of Investigation, the Inspector General of  
24 the Department of Health and Human Services,  
25 and the States (including a medicaid fraud and

1 abuse control unit described in section  
2 1903(q)). Such information shall be dissemi-  
3 nated no less frequently than quarterly.

4 “(2) LIMITED WAIVER AUTHORITY.—The Sec-  
5 retary shall waive only such requirements of this sec-  
6 tion and of titles XI and XIX as are necessary to  
7 carry out paragraph (1).”.

8 (2) FUNDING.—Section 1817(k)(4) of such Act  
9 (42 U.S.C. 1395i(k)(4)), as amended by section  
10 5204 of this Act, is amended—

11 (A) in subparagraph (A), by striking “sub-  
12 paragraph (B)” and inserting “subparagraphs  
13 (B), (C), and (D)”; and

14 (B) by adding at the end the following:

15 “(D) EXPANSION OF THE MEDICARE-MED-  
16 ICAID DATA MATCH PROGRAM.—The amount  
17 appropriated under subparagraph (A) for a fis-  
18 cal year is further increased as follows for pur-  
19 poses of carrying out section 1893(b)(6) for the  
20 respective fiscal year:

21 “(i) \$12,000,000 for fiscal year 2006.

22 “(ii) \$24,000,000 for fiscal year 2007.

23 “(iii) \$36,000,000 for fiscal year  
24 2008.

1                   “(iv) \$48,000,000 for fiscal year  
2                   2009.

3                   “(v) \$60,000,000 for fiscal year 2010  
4                   and each fiscal year thereafter.”.

5           (e) DELAYED EFFECTIVE DATE FOR CHAPTER.—Ex-  
6 cept as otherwise provided in this chapter, in the case of  
7 a State plan under title XIX of the Social Security Act  
8 which the Secretary determines requires State legislation  
9 in order for the plan to meet the additional requirements  
10 imposed by the amendments made by a provision of this  
11 chapter, the State plan shall not be regarded as failing  
12 to comply with the requirements of such Act solely on the  
13 basis of its failure to meet these additional requirements  
14 before the first day of the first calendar quarter beginning  
15 after the close of the first regular session of the State leg-  
16 isature that begins after the date of enactment of this  
17 Act. For purposes of the previous sentence, in the case  
18 of a State that has a 2-year legislative session, each year  
19 of the session shall be considered to be a separate regular  
20 session of the State legislature.

21 **SEC. 6036. ENHANCING THIRD PARTY IDENTIFICATION AND**  
22 **PAYMENT.**

23           (a) CLARIFICATION OF THIRD PARTIES LEGALLY  
24 RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH

1 CARE ITEM OR SERVICE.—Section 1902(a)(25) of the So-  
2 cial Security Act (42 U.S.C. 1396a(a)(25)) is amended—

3 (1) in subparagraph (A), in the matter pre-  
4 ceding clause (i)—

5 (A) by inserting “, self-insured plans”  
6 after “health insurers”; and

7 (B) by striking “and health maintenance  
8 organizations” and inserting “managed care or-  
9 ganizations, pharmacy benefit managers, or  
10 other parties that are, by statute, contract, or  
11 agreement, legally responsible for payment of a  
12 claim for a health care item or service”; and

13 (2) in subparagraph (G)—

14 (A) by inserting “a self-insured plan,”  
15 after “1974,”; and

16 (B) by striking “and a health maintenance  
17 organization” and inserting “a managed care  
18 organization, a pharmacy benefit manager, or  
19 other party that is, by statute, contract, or  
20 agreement, legally responsible for payment of a  
21 claim for a health care item or service”.

22 (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE  
23 THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS  
24 DATA.—Section 1902(a)(25) of such Act (42 U.S.C.  
25 1396a(a)(25)) is amended—

1           (1) in subparagraph (G), by striking “and” at  
2     the end;

3           (2) in subparagraph (H), by adding “and” after  
4     the semicolon at the end; and

5           (3) by inserting after subparagraph (H), the  
6     following:

7           “(I) that the State shall provide assur-  
8     ances satisfactory to the Secretary that the  
9     State has in effect laws requiring health insur-  
10    ers, including self-insured plans, group health  
11    plans (as defined in section 607(1) of the Em-  
12    ployee Retirement Income Security Act of  
13    1974), service benefit plans, managed care or-  
14    ganizations, pharmacy benefit managers, or  
15    other parties that are, by statute, contract, or  
16    agreement, legally responsible for payment of a  
17    claim for a health care item or service, as a  
18    condition of doing business in the State, to—

19           “(i) provide, with respect to individ-  
20    uals who are eligible for, or are provided,  
21    medical assistance under the State plan,  
22    upon the request of the State, information  
23    to determine during what period the indi-  
24    vidual or their spouses or their dependents  
25    may be (or may have been) covered by a

1 health insurer and the nature of the cov-  
2 erage that is or was provided by the health  
3 insurer (including the name, address, and  
4 identifying number of the plan) in a man-  
5 ner prescribed by the Secretary;

6 “(ii) accept the State’s right of recov-  
7 ery and the assignment to the State of any  
8 right of an individual or other entity to  
9 payment from the party for an item or  
10 service for which payment has been made  
11 under the State plan;

12 “(iii) respond to any inquiry by the  
13 State regarding a claim for payment for  
14 any health care item or service that is sub-  
15 mitted not later than 3 years after the  
16 date of the provision of such health care  
17 item or service; and

18 “(iv) agree not to deny a claim sub-  
19 mitted by the State solely on the basis of  
20 the date of submission of the claim, the  
21 type or format of the claim form, or a fail-  
22 ure to present proper documentation at the  
23 point-of-sale that is the basis of the claim,  
24 if—

1                   “(I) the claim is submitted by  
2                   the State within the 3-year period be-  
3                   ginning on the date on which the item  
4                   or service was furnished; and

5                   “(II) any action by the State to  
6                   enforce its rights with respect to such  
7                   claim is commenced within 6 years of  
8                   the State’s submission of such  
9                   claim;”.

10           (c) EFFECTIVE DATE.—Except as provided in section  
11 6035(e), the amendments made by this section take effect  
12 on January 1, 2006.

13 **SEC. 6037. IMPROVED ENFORCEMENT OF DOCUMENTATION**  
14 **REQUIREMENTS.**

15           (a) IN GENERAL.—Section 1903 of the Social Secu-  
16 rity Act (42 U.S.C. 1396b) is amended—

17                   (1) in subsection (i), as amended by section 104  
18                   of Public Law 109–91 and section 6031(a) of this  
19                   Act—

20                           (A) by striking “or” at the end of para-  
21                           graph (21);

22                           (B) by striking the period at the end of  
23                           paragraph (22) and inserting “; or”; and

24                           (C) by inserting after paragraph (22) the  
25                   following new paragraph:



1           “(23) with respect to amounts expended for  
2           medical assistance for an individual who declares  
3           under section 1137(d)(1)(A) to be a citizen or na-  
4           tional of the United States for purposes of estab-  
5           lishing eligibility for benefits under this title, unless  
6           the requirement of subsection (x) is met.”; and

7           (2) by adding at the end the following new sub-  
8           section:

9           “(x)(1) For purposes of subsection (i)(23), the re-  
10          quirement of this subsection is, with respect to an indi-  
11          vidual declaring to be a citizen or national of the United  
12          States, that, subject to paragraph (2), there is presented  
13          satisfactory documentary evidence of citizenship or nation-  
14          ality (as defined in paragraph (3)) of the individual.

15          “(2) The requirement of paragraph (1) shall not  
16          apply to an alien who is eligible for medical assistance  
17          under this title—

18                 “(A) and is entitled to or enrolled for benefits  
19                 under any part of title XVIII;

20                 “(B) on the basis of receiving supplemental se-  
21                 curity income benefits under title XVI; or

22                 “(C) on such other basis as the Secretary may  
23                 specify under which satisfactory documentary evi-  
24                 dence of citizenship or nationality had been pre-  
25                 viously presented.

1       “(3)(A) For purposes of this subsection, the term  
2 ‘satisfactory documentary evidence of citizenship or na-  
3 tionality’ means—

4           “(i) any document described in subparagraph  
5 (B); or

6           “(ii) a document described in subparagraph (C)  
7 and a document described in subparagraph (D).

8       “(B) The following are documents described in this  
9 subparagraph:

10           “(i) A United States passport.

11           “(ii) Form N-550 or N-570 (Certificate of  
12 Naturalization).

13           “(iii) Form N-560 or N-561 (Certificate of  
14 United States Citizenship).

15           “(iv) A valid State-issued driver’s license or  
16 other identity document described in section  
17 274A(b)(1)(D) of the Immigration and Nationality  
18 Act, but only if the State issuing the license or such  
19 document requires proof of United States citizenship  
20 before issuance of such license or document or ob-  
21 tains a social security number from the applicant  
22 and verifies before certification that such number is  
23 valid and assigned to the applicant who is a citizen.

24           “(v) Such other document as the Secretary may  
25 specify, by regulation, that provides proof of United

1 States citizenship or nationality and that provides a  
2 reliable means of documentation of personal identity.

3 “(C) The following are documents described in this  
4 subparagraph:

5 “(i) A certificate of birth in the United States.

6 “(ii) Form FS-545 or Form DS-1350 (Certifi-  
7 cation of Birth Abroad).

8 “(iii) Form I-97 (United States Citizen Identi-  
9 fication Card).

10 “(iv) Form FS-240 (Report of Birth Abroad of  
11 a Citizen of the United States).

12 “(v) Such other document (not described in  
13 subparagraph (B)(iv)) as the Secretary may specify  
14 that provides proof of United States citizenship or  
15 nationality.

16 “(D) The following are documents described in this  
17 subparagraph:

18 “(i) Any identity document described in section  
19 274A(b)(1)(D) of the Immigration and Nationality  
20 Act.

21 “(ii) Any other documentation of personal iden-  
22 tity of such other type as the Secretary finds, by  
23 regulation, provides a reliable means of identifica-  
24 tion.

1       “(E) A reference in this paragraph to a form includes  
2 a reference to any successor form.”.

3       (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall apply to determinations of initial eligi-  
5 bility for medical assistance made on or after July 1,  
6 2006, and to redeterminations of eligibility made on or  
7 after such date in the case of individuals for whom the  
8 requirement of section 1903(z) of the Social Security Act,  
9 as added by such amendments, was not previously met.

10       (c) IMPLEMENTATION REQUIREMENT.—As soon as  
11 practicable after the date of enactment of this Act, the  
12 Secretary of Health and Human Services shall establish  
13 an outreach program that is designed to educate individ-  
14 uals who are likely to be affected by the requirements of  
15 subsections (i)(23) and (x) of section 1903 of the Social  
16 Security Act (as added by subsection (a)) about such re-  
17 quirements and how they may be satisfied.

## 18       **CHAPTER 4—FLEXIBILITY IN COST**

### 19               **SHARING AND BENEFITS**

#### 20       **SEC. 6041. STATE OPTION FOR ALTERNATIVE MEDICAID**

##### 21               **PREMIUMS AND COST SHARING.**

22       (a) IN GENERAL.—Title XIX of the Social Security  
23 Act is amended by inserting after section 1916 the fol-  
24 lowing new section:

1 “STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST  
2 SHARING

3 “SEC. 1916A. (a) STATE FLEXIBILITY.—

4 “(1) IN GENERAL.—Notwithstanding sections  
5 1916 and 1902(a)(10)(B), a State, at its option and  
6 through a State plan amendment, may impose pre-  
7 miums and cost sharing for any group of individuals  
8 (as specified by the State) and for any type of serv-  
9 ices (other than drugs for which cost sharing may be  
10 imposed under subsection (c)), and may vary such  
11 premiums and cost sharing among such groups or  
12 types, consistent with the limitations established  
13 under this section. Nothing in this section shall be  
14 construed as superseding (or preventing the applica-  
15 tion of) section 1916(g).

16 “(2) DEFINITIONS.—In this section:

17 “(A) PREMIUM.—The term ‘premium’ in-  
18 cludes any enrollment fee or similar charge.

19 “(B) COST SHARING.—The term ‘cost  
20 sharing’ includes any deduction, copayment, or  
21 similar charge.

22 “(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

23 “(1) INDIVIDUALS WITH FAMILY INCOME BE-  
24 TWEEN 100 AND 150 PERCENT OF THE POVERTY  
25 LINE.—In the case of an individual whose family in-

1       come exceeds 100 percent, but does not exceed 150  
2       percent, of the poverty line applicable to a family of  
3       the size involved, subject to subsections (c)(2) and  
4       (e)(2)(A)—

5               “(A) no premium may be imposed under  
6       the plan; and

7               “(B) with respect to cost sharing—

8                       “(i) the cost sharing imposed under  
9       subsection (a) with respect to any item or  
10      service may not exceed 10 percent of the  
11      cost of such item or service; and

12                      “(ii) the total aggregate amount of  
13      cost sharing imposed under this section  
14      (including any cost sharing imposed under  
15      subsection (c) or (e)) for all individuals in  
16      the family may not exceed 5 percent of the  
17      family income of the family involved, as  
18      applied on a quarterly or monthly basis (as  
19      specified by the State).

20               “(2) INDIVIDUALS WITH FAMILY INCOME  
21      ABOVE 150 PERCENT OF THE POVERTY LINE.—In  
22      the case of an individual whose family income ex-  
23      ceeds 150 percent of the poverty line applicable to  
24      a family of the size involved, subject to subsections  
25      (c)(2) and (e)(2)(A)—

1           “(A) the total aggregate amount of pre-  
2           miums and cost sharing imposed under this sec-  
3           tion (including any cost sharing imposed under  
4           subsection (c) or (e)) for all individuals in the  
5           family may not exceed 5 percent of the family  
6           income of the family involved, as applied on a  
7           quarterly or monthly basis (as specified by the  
8           State); and

9           “(B) with respect to cost sharing, the cost  
10          sharing imposed with respect to any item or  
11          service under subsection (a) may not exceed 20  
12          percent of the cost of such item or service.

13          “(3) ADDITIONAL LIMITATIONS.—

14          “(A) PREMIUMS.—No premiums shall be  
15          imposed under this section with respect to the  
16          following:

17                 “(i) Individuals under 18 years of age  
18                 that are required to be provided medical  
19                 assistance under section 1902(a)(10)(A)(i),  
20                 and including individuals with respect to  
21                 whom aid or assistance is made available  
22                 under part B of title IV to children in fos-  
23                 ter care and individuals with respect to  
24                 whom adoption or foster care assistance is

1 made available under part E of such title,  
2 without regard to age.

3 “(ii) Pregnant women.

4 “(iii) Any terminally ill individual who  
5 is receiving hospice care (as defined in sec-  
6 tion 1905(o)).

7 “(iv) Any individual who is an inpa-  
8 tient in a hospital, nursing facility, inter-  
9 mediate care facility for the mentally re-  
10 tarder, or other medical institution, if such  
11 individual is required, as a condition of re-  
12 ceiving services in such institution under  
13 the State plan, to spend for costs of med-  
14 ical care all but a minimal amount of the  
15 individual’s income required for personal  
16 needs.

17 “(v) Women who are receiving medical  
18 assistance by virtue of the application of  
19 sections 1902(a)(10)(A)(ii)(XVIII) and  
20 1902(aa).

21 “(B) COST SHARING.—Subject to the suc-  
22 ceeding provisions of this section, no cost shar-  
23 ing shall be imposed under subsection (a) with  
24 respect to the following:



1           “(i) Services furnished to individuals  
2           under 18 years of age that are required to  
3           be provided medical assistance under sec-  
4           tion 1902(a)(10)(A)(i), and including serv-  
5           ices furnished to individuals with respect  
6           to whom aid or assistance is made avail-  
7           able under part B of title IV to children in  
8           foster care and individuals with respect to  
9           whom adoption or foster care assistance is  
10          made available under part E of such title,  
11          without regard to age.

12          “(ii) Preventive services (such as well  
13          baby and well child care and immuniza-  
14          tions) provided to children under 18 years  
15          of age regardless of family income.

16          “(iii) Services furnished to pregnant  
17          women, if such services relate to the preg-  
18          nancy or to any other medical condition  
19          which may complicate the pregnancy.

20          “(iv) Services furnished to a termi-  
21          nally ill individual who is receiving hospice  
22          care (as defined in section 1905(o)).

23          “(v) Services furnished to any indi-  
24          vidual who is an inpatient in a hospital,  
25          nursing facility, intermediate care facility

1           for the mentally retarded, or other medical  
2           institution, if such individual is required,  
3           as a condition of receiving services in such  
4           institution under the State plan, to spend  
5           for costs of medical care all but a minimal  
6           amount of the individual's income required  
7           for personal needs.

8           “(vi) Emergency services (as defined  
9           by the Secretary for purposes of section  
10          1916(a)(2)(D)).

11          “(vii) Family planning services and  
12          supplies described in section  
13          1905(a)(4)(C).

14          “(viii) Services furnished to women  
15          who are receiving medical assistance by  
16          virtue of the application of sections  
17          1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

18          “(C) CONSTRUCTION.—Nothing in this  
19          paragraph shall be construed as preventing a  
20          State from exempting additional classes of indi-  
21          viduals from premiums under this section or  
22          from exempting additional individuals or serv-  
23          ices from cost sharing under subsection (a).

24          “(4) DETERMINATIONS OF FAMILY INCOME.—

25          In applying this subsection, family income shall be

1       determined in a manner specified by the State for  
2       purposes of this subsection, including the use of  
3       such disregards as the State may provide. Family in-  
4       come shall be determined for such period and at  
5       such periodicity as the State may provide under this  
6       title.

7           “(5) POVERTY LINE DEFINED.—For purposes  
8       of this section, the term ‘poverty line’ has the mean-  
9       ing given such term in section 673(2) of the Com-  
10      munity Services Block Grant Act (42 U.S.C.  
11      9902(2)), including any revision required by such  
12      section.

13          “(6) CONSTRUCTION.—Nothing in this section  
14      shall be construed—

15           “(A) as preventing a State from further  
16      limiting the premiums and cost sharing imposed  
17      under this section beyond the limitations pro-  
18      vided under this section;

19           “(B) as affecting the authority of the Sec-  
20      retary through waiver to modify limitations on  
21      premiums and cost sharing under this section;  
22      or

23           “(C) as affecting any such waiver of re-  
24      quirements in effect under this title before the  
25      date of the enactment of this section with re-

1           gard to the imposition of premiums and cost  
2           sharing.

3           “(d) ENFORCEABILITY OF PREMIUMS AND OTHER  
4   COST SHARING.—

5           “(1) PREMIUMS.—Notwithstanding section  
6   1916(c)(3) and section 1902(a)(10)(B), a State  
7   may, at its option, condition the provision of medical  
8   assistance for an individual upon prepayment of a  
9   premium authorized to be imposed under this sec-  
10   tion, or may terminate eligibility for such medical  
11   assistance on the basis of failure to pay such a pre-  
12   mium but shall not terminate eligibility of an indi-  
13   vidual for medical assistance under this title on the  
14   basis of failure to pay any such premium until such  
15   failure continues for a period of not less than 60  
16   days. A State may apply the previous sentence for  
17   some or all groups of beneficiaries as specified by  
18   the State and may waive payment of any such pre-  
19   mium in any case where the State determines that  
20   requiring such payment would create an undue hard-  
21   ship.

22           “(2) COST SHARING.—Notwithstanding section  
23   1916(e) or any other provision of law, a State may  
24   permit a provider participating under the State plan  
25   to require, as a condition for the provision of care,

1 items, or services to an individual entitled to medical  
2 assistance under this title for such care, items, or  
3 services, the payment of any cost sharing authorized  
4 to be imposed under this section with respect to  
5 such care, items, or services. Nothing in this para-  
6 graph shall be construed as preventing a provider  
7 from reducing or waiving the application of such  
8 cost sharing on a case-by-case basis.”.

9 (b) INDEXING NOMINAL COST SHARING AND CON-  
10 FORMING AMENDMENT.—Section 1916 of such Act (42  
11 U.S.C. 1396o) is amended—

12 (1) in subsection (f), by inserting “and section  
13 1916A” after “(b)(3)”; and

14 (2) by adding at the end the following new sub-  
15 section:

16 “(h) In applying this section and subsections (c) and  
17 (e) of section 1916A, with respect to cost sharing that is  
18 ‘nominal’ in amount, the Secretary shall increase such  
19 ‘nominal’ amounts for each year (beginning with 2006)  
20 by the annual percentage increase in the medical care  
21 component of the consumer price index for all urban con-  
22 sumers (U.S. city average) as rounded up in an appro-  
23 priate manner.”.

24 (c) GAO STUDY OF IMPACT OF PREMIUMS AND COST  
25 SHARING.—The Comptroller General of the United States

1 shall conduct a study on the impact of premiums and cost  
2 sharing under the Medicaid program on access to, and uti-  
3 lization of, services. Not later than January 1, 2008, the  
4 Comptroller General shall submit to Congress a report on  
5 such study.

6 (d) EFFECTIVE DATE.—The amendments made by  
7 this section shall apply to cost sharing imposed for items  
8 and services furnished on or after March 31, 2006.

9 **SEC. 6042. SPECIAL RULES FOR COST SHARING FOR PRE-**  
10 **SCRIPTION DRUGS.**

11 (a) IN GENERAL.—Section 1916A of the Social Secu-  
12 rity Act, as inserted by section 6041(a), is amended by  
13 inserting after subsection (b) the following new subsection:

14 “(c) SPECIAL RULES FOR COST SHARING FOR PRE-  
15SCRIPTION DRUGS.—

16 “(1) IN GENERAL.—In order to encourage  
17 beneficiaries to use drugs (in this subsection referred  
18 to as ‘preferred drugs’) identified by the State as the  
19 least (or less) costly effective prescription drugs  
20 within a class of drugs (as defined by the State),  
21 with respect to one or more groups of beneficiaries  
22 specified by the State, subject to paragraph (2), the  
23 State may—

24 “(A) provide cost sharing (instead of the  
25 level of cost sharing otherwise permitted under

1 section 1916, but subject to paragraphs (2) and  
2 (3)) with respect to drugs that are not pre-  
3 ferred drugs within a class; and

4 “(B) waive or reduce the cost sharing oth-  
5 erwise applicable for preferred drugs within  
6 such class and shall not apply any such cost  
7 sharing for such preferred drugs for individuals  
8 for whom cost sharing may not otherwise be im-  
9 posed under subsection (b)(3)(B).

10 “(2) LIMITATIONS.—

11 “(A) BY INCOME GROUP.—In no case may  
12 the cost sharing under paragraph (1)(A) with  
13 respect to a non-preferred drug exceed—

14 “(i) in the case of an individual whose  
15 family income does not exceed 150 percent  
16 of the poverty line applicable to a family of  
17 the size involved, the amount of nominal  
18 cost sharing (as otherwise determined  
19 under section 1916); or

20 “(ii) in the case of an individual  
21 whose family income exceeds 150 percent  
22 of the poverty line applicable to a family of  
23 the size involved, 20 percent of the cost of  
24 the drug.

1                   “(B) LIMITATION TO NOMINAL FOR EX-  
2                   EMPTY POPULATIONS.—In the case of an indi-  
3                   vidual who is otherwise not subject to cost shar-  
4                   ing due to the application of subsection  
5                   (b)(3)(B), any cost sharing under paragraph  
6                   (1)(A) with respect to a non-preferred drug  
7                   may not exceed a nominal amount (as otherwise  
8                   determined under section 1916).

9                   “(C) CONTINUED APPLICATION OF AGGRE-  
10                  GATE CAP.—In addition to the limitations im-  
11                  posed under subparagraphs (A) and (B), any  
12                  cost sharing under paragraph (1)(A) continues  
13                  to be subject to the aggregate cap on cost shar-  
14                  ing applied under paragraph (1) or (2) of sub-  
15                  section (b), as the case may be.

16               “(3) WAIVER.—In carrying out paragraph (1),  
17               a State shall provide for the application of cost shar-  
18               ing levels applicable to a preferred drug in the case  
19               of a drug that is not a preferred drug if the pre-  
20               scribing physician determines that the preferred  
21               drug for treatment of the same condition either  
22               would not be as effective for the individual or would  
23               have adverse effects for the individual or both.

24               “(4) EXCLUSION AUTHORITY.—Nothing in this  
25               subsection shall be construed as preventing a State



1 from excluding specified drugs or classes of drugs  
2 from the application of paragraph (1).”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to cost sharing imposed for  
5 items and services furnished on or after March 31, 2006.

6 **SEC. 6043. EMERGENCY ROOM COPAYMENTS FOR NON-**  
7 **EMERGENCY CARE.**

8 (a) IN GENERAL.—Section 1916A of the Social Secu-  
9 rity Act, as inserted by section 6041 and as amended by  
10 section 6042, is further amended by adding at the end  
11 the following new subsection:

12 “(e) STATE OPTION FOR PERMITTING HOSPITALS  
13 TO IMPOSE COST SHARING FOR NON-EMERGENCY CARE  
14 FURNISHED IN AN EMERGENCY DEPARTMENT.—

15 “(1) IN GENERAL.—Notwithstanding section  
16 1916 and section 1902(a)(1) or the previous provi-  
17 sions of this section, but subject to the limitations  
18 of paragraph (2), a State may, by amendment to its  
19 State plan under this title, permit a hospital to im-  
20 pose cost sharing for non-emergency services fur-  
21 nished to an individual (within one or more groups  
22 of individuals specified by the State) in the hospital  
23 emergency department under this subsection if the  
24 following conditions are met:

1           “(A) ACCESS TO NON-EMERGENCY ROOM  
2 PROVIDER.—The individual has actually avail-  
3 able and accessible (as such terms are applied  
4 by the Secretary under section 1916(b)(3)) an  
5 alternate non-emergency services provider with  
6 respect to such services.

7           “(B) NOTICE.—The hospital must inform  
8 the beneficiary after receiving an appropriate  
9 medical screening examination under section  
10 1867 and after a determination has been made  
11 that the individual does not have an emergency  
12 medical condition, but before providing the non-  
13 emergency services, of the following:

14           “(i) The hospital may require the pay-  
15 ment of the State specified cost sharing  
16 before the service can be provided.

17           “(ii) The name and location of an al-  
18 ternate non-emergency services provider  
19 (described in subparagraph (A)) that is ac-  
20 tually available and accessible (as described  
21 in such subparagraph).

22           “(iii) The fact that such alternate  
23 provider can provide the services without  
24 the imposition of cost sharing described in  
25 clause (i).

1                   “(iv) The hospital provides a referral  
2                   to coordinate scheduling of this treatment.  
3                   Nothing in this subsection shall be construed as  
4                   preventing a State from applying (or waiving)  
5                   cost sharing otherwise permissible under this  
6                   section to services described in clause (iii).

7                   “(2) LIMITATIONS.—

8                   “(A) FOR POOREST BENEFICIARIES.—In  
9                   the case of an individual described in subsection  
10                  (b)(1), the cost sharing imposed under this sub-  
11                  section may not exceed twice the amount deter-  
12                  mined to be nominal under section 1916, sub-  
13                  ject to the percent of income limitation other-  
14                  wise applicable under subsection (b)(1).

15                  “(B) APPLICATION TO EXEMPT POPU-  
16                  LATIONS.—In the case of an individual who is  
17                  otherwise not subject to cost sharing under sub-  
18                  section (b)(3), a State may impose cost sharing  
19                  under paragraph (1) for care in an amount that  
20                  does not exceed a nominal amount (as otherwise  
21                  determined under section 1916) so long as no  
22                  cost sharing is imposed to receive such care  
23                  through an outpatient department or other al-  
24                  ternative health care provider in the geographic

1 area of the hospital emergency department in-  
2 volved.

3 “(C) CONTINUED APPLICATION OF AGGRE-  
4 GATE CAP; RELATION TO OTHER COST SHAR-  
5 ING.—In addition to the limitations imposed  
6 under subparagraphs (A) and (B), any cost  
7 sharing under paragraph (1) is subject to the  
8 aggregate cap on cost sharing applied under  
9 paragraph (1) or (2) of subsection (b), as the  
10 case may be. Cost sharing imposed for services  
11 under this subsection shall be instead of any  
12 cost sharing that may be imposed for such serv-  
13 ices under subsection (a).

14 “(3) CONSTRUCTION.—Nothing in this section  
15 shall be construed—

16 “(A) to limit a hospital’s obligations with  
17 respect to screening and stabilizing treatment  
18 of an emergency medical condition under sec-  
19 tion 1867; or

20 “(B) to modify any obligations under ei-  
21 ther State or Federal standards relating to the  
22 application of a prudent-layperson standard  
23 with respect to payment or coverage of emer-  
24 gency services by any managed care organiza-  
25 tion.

1           “(4) STANDARD REGARDING IMPOSITION OF  
2           COST SHARING.—No hospital or physician shall be  
3           liable in any civil action or proceeding for the im-  
4           position of cost-sharing under this section, absent a  
5           finding by clear and convincing evidence of gross  
6           negligence by the hospital or physician. The previous  
7           sentence shall not affect any liability under section  
8           1867 or otherwise applicable under State law based  
9           upon the provision of (or failure to provide) care.

10           “(5) DEFINITIONS.—For purposes of this sub-  
11           section:

12           “(A) NON-EMERGENCY SERVICES.—The  
13           term ‘non-emergency services’ means any care  
14           or services furnished in a emergency depart-  
15           ment of a hospital that the physician deter-  
16           mines do not constitute an appropriate medical  
17           screening examination or stabilizing examina-  
18           tion and treatment required to be provided by  
19           the hospital under section 1867.

20           “(B) ALTERNATE NON-EMERGENCY SERV-  
21           ICES PROVIDER.—The term ‘alternative non-  
22           emergency services provider’ means, with re-  
23           spect to non-emergency services for the diag-  
24           nosis or treatment of a condition, a health care  
25           provider, such as a physician’s office, health

1           care clinic, community health center, hospital  
2           outpatient department, or similar health care  
3           provider, that can provide clinically appropriate  
4           services for the diagnosis or treatment of a con-  
5           dition contemporaneously with the provision of  
6           the non-emergency services that would be pro-  
7           vided in a emergency department of a hospital  
8           for the diagnosis or treatment of a condition,  
9           and that is participating in the program under  
10          this title.”.

11          (b) GRANT FUNDS FOR ESTABLISHMENT OF ALTER-  
12         NATE NON-EMERGENCY SERVICES PROVIDERS.—Section  
13         1903 of the Social Security Act (42 U.S.C. 1396b), as  
14         amended by section 6037(a)(2), is amended by adding at  
15         the end the following new subsection:

16                 “(y) PAYMENTS FOR ESTABLISHMENT OF ALTER-  
17         NATE NON-EMERGENCY SERVICES PROVIDERS.—

18                 “(1) PAYMENTS.—In addition to the payments  
19                 otherwise provided under subsection (a), subject to  
20                 paragraph (2), the Secretary shall provide for pay-  
21                 ments to States under such subsection for the estab-  
22                 lishment of alternate non-emergency service pro-  
23                 viders (as defined in section 1916A(e)(5)(B)), or  
24                 networks of such providers.

1           “(2) LIMITATION.—The total amount of pay-  
2           ments under this subsection shall not exceed  
3           \$50,000,000 during the 4-year period beginning  
4           with 2006. This subsection constitutes budget au-  
5           thority in advance of appropriations Acts and rep-  
6           resents the obligation of the Secretary to provide for  
7           the payment of amounts provided under this sub-  
8           section.

9           “(3) PREFERENCE.—In providing for payments  
10          to States under this subsection, the Secretary shall  
11          provide preference to States that establish, or pro-  
12          vide for, alternate non-emergency services providers  
13          or networks of such providers that—

14               “(A) serve rural or underserved areas  
15               where beneficiaries under this title may not  
16               have regular access to providers of primary care  
17               services; or

18               “(B) are in partnership with local commu-  
19               nity hospitals.

20          “(4) FORM AND MANNER OF PAYMENT.—Pay-  
21          ment to a State under this subsection shall be made  
22          only upon the filing of such application in such form  
23          and in such manner as the Secretary shall specify.  
24          Payment to a State under this subsection shall be

1       made in the same manner as other payments under  
2       section 1903(a).”.

3       (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to non-emergency services fur-  
5 nished on or after January 1, 2007.

6 **SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.**

7       (a) IN GENERAL.—Title XIX of the Social Security  
8 Act, as amended by section 6035, is amended by redesignig-  
9 nating section 1937 as section 1938 and by inserting after  
10 section 1936 the following new section:

11           “STATE FLEXIBILITY IN BENEFIT PACKAGES

12           “SEC. 1937. (a) STATE OPTION OF PROVIDING  
13 BENCHMARK BENEFITS.—

14                   “(1) AUTHORITY.—

15                           “(A) IN GENERAL.—Notwithstanding any  
16 other provision of this title, a State, at its op-  
17 tion as a State plan amendment, may provide  
18 for medical assistance under this title to indi-  
19 viduals within one or more groups of individuals  
20 specified by the State through enrollment in  
21 coverage that provides—

22                                   “(i) benchmark coverage described in  
23 subsection (b)(1) or benchmark equivalent  
24 coverage described in subsection (b)(2);  
25 and



1                   “(ii) for any child under 19 years of  
2                   age who is covered under the State plan  
3                   under section 1902(a)(10)(A), wrap-  
4                   around benefits to the benchmark coverage  
5                   or benchmark equivalent coverage con-  
6                   sisting of early and periodic screening, di-  
7                   agnostic, and treatment services defined in  
8                   section 1905(r).

9                   “(B) LIMITATION.—The State may only  
10                  exercise the option under subparagraph (A) for  
11                  an individual eligible under an eligibility cat-  
12                  egory that had been established under the State  
13                  plan on or before the date of the enactment of  
14                  this section.

15                  “(C) OPTION OF WRAP-AROUND BENE-  
16                  FITS.—In the case of coverage described in sub-  
17                  paragraph (A), a State, at its option, may pro-  
18                  vide such wrap-around or additional benefits as  
19                  the State may specify.

20                  “(D) TREATMENT AS MEDICAL ASSIST-  
21                  ANCE.—Payment of premiums for such cov-  
22                  erage under this subsection shall be treated as  
23                  payment of other insurance premiums described  
24                  in the third sentence of section 1905(a).

25                  “(2) APPLICATION.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), a State may require that a  
3           full-benefit eligible individual (as defined in  
4           subparagraph (C)) within a group obtain bene-  
5           fits under this title through enrollment in cov-  
6           erage described in paragraph (1)(A). A State  
7           may apply the previous sentence to individuals  
8           within 1 or more groups of such individuals.

9           “(B) LIMITATION ON APPLICATION.—A  
10          State may not require under subparagraph (A)  
11          an individual to obtain benefits through enroll-  
12          ment described in paragraph (1)(A) if the indi-  
13          vidual is within one of the following categories  
14          of individuals:

15               “(i) MANDATORY PREGNANT  
16               WOMEN.—The individual is a pregnant  
17               woman who is required to be covered under  
18               the State plan under section  
19               1902(a)(10)(A)(i).

20               “(ii) BLIND OR DISABLED INDIVID-  
21               UALS.—The individual qualifies for medical  
22               assistance under the State plan on the  
23               basis of being blind or disabled (or being  
24               treated as being blind or disabled) without  
25               regard to whether the individual is eligible

1 for supplemental security income benefits  
2 under title XVI on the basis of being blind  
3 or disabled and including an individual  
4 who is eligible for medical assistance on  
5 the basis of section 1902(e)(3).

6 “(iii) DUAL ELIGIBLES.—The indi-  
7 vidual is entitled to benefits under any  
8 part of title XVIII.

9 “(iv) TERMINALLY ILL HOSPICE PA-  
10 TIENTS.—The individual is terminally ill  
11 and is receiving benefits for hospice care  
12 under this title.

13 “(v) ELIGIBLE ON BASIS OF INSTITU-  
14 TIONALIZATION.—The individual is an in-  
15 patient in a hospital, nursing facility, in-  
16 termediate care facility for the mentally re-  
17 tardated, or other medical institution, and is  
18 required, as a condition of receiving serv-  
19 ices in such institution under the State  
20 plan, to spend for costs of medical care all  
21 but a minimal amount of the individual’s  
22 income required for personal needs.

23 “(vi) MEDICALLY FRAIL AND SPECIAL  
24 MEDICAL NEEDS INDIVIDUALS.—The indi-  
25 vidual is medically frail or otherwise an in-

1           dividual with special medical needs (as  
2           identified in accordance with regulations of  
3           the Secretary).

4           “(vii) BENEFICIARIES QUALIFYING  
5           FOR LONG-TERM CARE SERVICES.—The in-  
6           dividual qualifies based on medical condi-  
7           tion for medical assistance for long-term  
8           care services described in section  
9           1917(c)(1)(C).

10          “(viii) CHILDREN IN FOSTER CARE  
11          RECEIVING CHILD WELFARE SERVICES AND  
12          CHILDREN RECEIVING FOSTER CARE OR  
13          ADOPTION ASSISTANCE.—The individual is  
14          an individual with respect to whom aid or  
15          assistance is made available under part B  
16          of title IV to children in foster care and in-  
17          dividuals with respect to whom adoption or  
18          foster care assistance is made available  
19          under part E of such such title, without re-  
20          gard to age.

21          “(ix) TANF AND SECTION 1931 PAR-  
22          ENTS.—The individual qualifies for med-  
23          ical assistance on the basis of eligibility to  
24          receive assistance under a State plan fund-  
25          ed under part A of title IV (as in effect on

1 or after the welfare reform effective date  
2 defined in section 1931(i)).

3 “(x) WOMEN IN THE BREAST OR CER-  
4 VICAL CANCER PROGRAM.—The individual  
5 is a woman who is receiving medical assist-  
6 ance by virtue of the application of sec-  
7 tions 1902(a)(10)(A)(ii)(XVIII) and  
8 1902(aa).

9 “(xii) LIMITED SERVICES BENE-  
10 FICIARIES.—The individual—

11 “(I) qualifies for medical assist-  
12 ance on the basis of section  
13 1902(a)(10)(A)(ii)(XII); or

14 “(II) is not a qualified alien (as  
15 defined in section 431 of the Personal  
16 Responsibility and Work Opportunity  
17 Reconciliation Act of 1996) and re-  
18 ceives care and services necessary for  
19 the treatment of an emergency med-  
20 ical condition in accordance with sec-  
21 tion 1903(v).

22 “(C) FULL-BENEFIT ELIGIBLE INDIVID-  
23 UALS.—

24 “(i) IN GENERAL.—For purposes of  
25 this paragraph, subject to clause (ii), the

1 term ‘full-benefit eligible individual’ means  
2 for a State for a month an individual who  
3 is determined eligible by the State for med-  
4 ical assistance for all services defined in  
5 section 1905(a) which are covered under  
6 the State plan under this title for such  
7 month under section 1902(a)(10)(A) or  
8 under any other category of eligibility for  
9 medical assistance for all such services  
10 under this title, as determined by the Sec-  
11 retary.

12 “(ii) EXCLUSION OF MEDICALLY  
13 NEEDY AND SPEND-DOWN POPULATIONS.—  
14 Such term shall not include an individual  
15 determined to be eligible by the State for  
16 medical assistance under section  
17 1902(a)(10)(C) or by reason of section  
18 1902(f) or otherwise eligible based on a re-  
19 duction of income based on costs incurred  
20 for medical or other remedial care.

21 “(b) BENCHMARK BENEFIT PACKAGES.—

22 “(1) IN GENERAL.—For purposes of subsection  
23 (a)(1), each of the following coverage shall be con-  
24 sidered to be benchmark coverage:

1           “(A) FEHBP-EQUIVALENT HEALTH IN-  
2 SURANCE COVERAGE.—The standard Blue  
3 Cross/Blue Shield preferred provider option  
4 service benefit plan, described in and offered  
5 under section 8903(1) of title 5, United States  
6 Code.

7           “(B) STATE EMPLOYEE COVERAGE.—A  
8 health benefits coverage plan that is offered and  
9 generally available to State employees in the  
10 State involved.

11           “(C) COVERAGE OFFERED THROUGH  
12 HMO.—The health insurance coverage plan  
13 that—

14                   “(i) is offered by a health mainte-  
15 nance organization (as defined in section  
16 2791(b)(3) of the Public Health Service  
17 Act), and

18                   “(ii) has the largest insured commer-  
19 cial, non-medicaid enrollment of covered  
20 lives of such coverage plans offered by  
21 such a health maintenance organization in  
22 the State involved.

23           “(D) SECRETARY-APPROVED COVERAGE.—  
24 Any other health benefits coverage that the Sec-  
25 retary determines, upon application by a State,

1 provides appropriate coverage for the popu-  
2 lation proposed to be provided such coverage.

3 “(2) BENCHMARK-EQUIVALENT COVERAGE.—

4 For purposes of subsection (a)(1), coverage that  
5 meets the following requirement shall be considered  
6 to be benchmark-equivalent coverage:

7 “(A) INCLUSION OF BASIC SERVICES.—

8 The coverage includes benefits for items and  
9 services within each of the following categories  
10 of basic services:

11 “(i) Inpatient and outpatient hospital  
12 services.

13 “(ii) Physicians’ surgical and medical  
14 services.

15 “(iii) Laboratory and x-ray services.

16 “(iv) Well-baby and well-child care,  
17 including age-appropriate immunizations.

18 “(v) Other appropriate preventive  
19 services, as designated by the Secretary.

20 “(B) AGGREGATE ACTUARIAL VALUE

21 EQUIVALENT TO BENCHMARK PACKAGE.—The  
22 coverage has an aggregate actuarial value that  
23 is at least actuarially equivalent to one of the  
24 benchmark benefit packages described in para-  
25 graph (1).



1           “(C) SUBSTANTIAL ACTUARIAL VALUE FOR  
2           ADDITIONAL SERVICES INCLUDED IN BENCH-  
3           MARK PACKAGE.—With respect to each of the  
4           following categories of additional services for  
5           which coverage is provided under the bench-  
6           mark benefit package used under subparagraph  
7           (B), the coverage has an actuarial value that is  
8           equal to at least 75 percent of the actuarial  
9           value of the coverage of that category of serv-  
10          ices in such package:

11                   “(i) Coverage of prescription drugs.

12                   “(ii) Mental health services.

13                   “(iii) Vision services.

14                   “(iv) Hearing services.

15          “(3) DETERMINATION OF ACTUARIAL VALUE.—  
16          The actuarial value of coverage of benchmark benefit  
17          packages shall be set forth in an actuarial opinion  
18          in an actuarial report that has been prepared—

19                   “(A) by an individual who is a member of  
20                   the American Academy of Actuaries;

21                   “(B) using generally accepted actuarial  
22                   principles and methodologies;

23                   “(C) using a standardized set of utilization  
24                   and price factors;

1           “(D) using a standardized population that  
2           is representative of the population involved;

3           “(E) applying the same principles and fac-  
4           tors in comparing the value of different cov-  
5           erage (or categories of services);

6           “(F) without taking into account any dif-  
7           ferences in coverage based on the method of de-  
8           livery or means of cost control or utilization  
9           used; and

10          “(G) taking into account the ability of a  
11          State to reduce benefits by taking into account  
12          the increase in actuarial value of benefits cov-  
13          erage offered under this title that results from  
14          the limitations on cost sharing under such cov-  
15          erage.

16          The actuary preparing the opinion shall select and  
17          specify in the memorandum the standardized set and  
18          population to be used under subparagraphs (C) and  
19          (D).

20          “(4) COVERAGE OF RURAL HEALTH CLINIC AND  
21          FQHC SERVICES.—Notwithstanding the previous pro-  
22          visions of this section, a State may not provide for  
23          medical assistance through enrollment of an indi-  
24          vidual with benchmark coverage or benchmark equiv-  
25          alent coverage under this section unless—

1           “(A) the individual has access, through  
2           such coverage or otherwise, to services de-  
3           scribed in subparagraphs (B) and (C) of section  
4           1905(a)(2); and

5           “(B) payment for such services is made in  
6           accordance with the requirements of section  
7           1902(bb).”.

8           (b) EFFECTIVE DATE.—The amendment made by  
9           subsection (a) takes effect on March 31, 2006.

10       **CHAPTER 5—STATE FINANCING UNDER**  
11                               **MEDICAID**

12       **SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX**  
13                               **REFORM.**

14           (a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the  
15           Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is  
16           amended to read as follows:

17                               “(viii) Services of managed care organiza-  
18           tions (including health maintenance organiza-  
19           tions, preferred provider organizations, and  
20           such other similar organizations as the Sec-  
21           retary may specify by regulation).”.

22           (b) EFFECTIVE DATE.—

23                               (1) IN GENERAL.—Subject to paragraph (2),  
24           the amendment made by subsection (a) shall be ef-  
25           fective as of the date of the enactment of this Act.

1 (2) DELAY IN EFFECTIVE DATE.—

2 (A) IN GENERAL.—Subject to subpara-  
3 graph (B), in the case of a State specified in  
4 subparagraph (B), the amendment made by  
5 subsection (a) shall be effective as of October 1,  
6 2009.

7 (B) SPECIFIED STATES.—For purposes of  
8 subparagraph (A), the States specified in this  
9 subparagraph are States that have enacted a  
10 law providing for a tax on the services of a  
11 medicaid managed care organization with a con-  
12 tract under section 1903(m) of the Social Secu-  
13 rity Act as of December 8, 2005.

14 (c) CLARIFICATION REGARDING NON-REGULATION  
15 OF TRANSFERS.—

16 (1) IN GENERAL.—Nothing in section 1903(w)  
17 of the Social Security Act (42 U.S.C. 1396b(w))  
18 shall be construed by the Secretary of Health and  
19 Human Services as prohibiting a State's use of  
20 funds as the non-Federal share of expenditures  
21 under title XIX of such Act where such funds are  
22 transferred from or certified by a publicly-owned re-  
23 gional medical center located in another State and  
24 described in paragraph (2), so long as the Secretary

1 determines that such use of funds is proper and in  
2 the interest of the program under title XIX.

3 (2) CENTER DESCRIBED.—A center described  
4 in this paragraph is a publicly-owned regional med-  
5 ical center that—

6 (A) provides level 1 trauma and burn care  
7 services;

8 (B) provides level 3 neonatal care services;

9 (C) is obligated to serve all patients, re-  
10 gardless of State of origin;

11 (D) is located within a Standard Metro-  
12 politan Statistical Area (SMSA) that includes  
13 at least 3 States, including the States described  
14 in paragraph (1);

15 (E) serves as a tertiary care provider for  
16 patients residing within a 125 mile radius; and

17 (F) meets the criteria for a dispropor-  
18 tionate share hospital under section 1923 of  
19 such Act in at least one State other than the  
20 one in which the center is located.

21 (3) EFFECTIVE PERIOD.—This subsection shall  
22 apply through December 31, 2006.

1   **SEC. 6052. REFORMS OF CASE MANAGEMENT AND TAR-**  
2                   **GETED CASE MANAGEMENT.**

3           (a) IN GENERAL.—Section 1915(g) of the Social Se-  
4   curity Act (42 U.S.C. 1396n(g)(2)) is amended by striking  
5   paragraph (2) and inserting the following:

6           “(2) For purposes of this subsection:

7                   “(A)(i) The term ‘case management services’  
8           means services which will assist individuals eligible  
9           under the plan in gaining access to needed medical,  
10          social, educational, and other services.

11                  “(ii) Such term includes the following:

12                          “(I) Assessment of an eligible individual to  
13                  determine service needs, including activities  
14                  that focus on needs identification, to determine  
15                  the need for any medical, educational, social, or  
16                  other services. Such assessment activities in-  
17                  clude the following:

18                                  “(aa) Taking client history.

19                                  “(bb) Identifying the needs of the in-  
20                  dividual, and completing related docu-  
21                  mentation.

22                                  “(cc) Gathering information from  
23                  other sources such as family members,  
24                  medical providers, social workers, and edu-  
25                  cators, if necessary, to form a complete as-  
26                  sessment of the eligible individual.

1           “(II) Development of a specific care plan  
2           based on the information collected through an  
3           assessment, that specifies the goals and actions  
4           to address the medical, social, educational, and  
5           other services needed by the eligible individual,  
6           including activities such as ensuring the active  
7           participation of the eligible individual and work-  
8           ing with the individual (or the individual’s au-  
9           thorized health care decision maker) and others  
10          to develop such goals and identify a course of  
11          action to respond to the assessed needs of the  
12          eligible individual.

13          “(III) Referral and related activities to  
14          help an individual obtain needed services, in-  
15          cluding activities that help link eligible individ-  
16          uals with medical, social, educational providers  
17          or other programs and services that are capable  
18          of providing needed services, such as making re-  
19          ferrals to providers for needed services and  
20          scheduling appointments for the individual.

21          “(IV) Monitoring and followup activities,  
22          including activities and contacts that are nec-  
23          essary to ensure the care plan is effectively im-  
24          plemented and adequately addressing the needs  
25          of the eligible individual, and which may be

1 with the individual, family members, providers,  
2 or other entities and conducted as frequently as  
3 necessary to help determine such matters as—

4 “(aa) whether services are being fur-  
5 nished in accordance with an individual’s  
6 care plan;

7 “(bb) whether the services in the care  
8 plan are adequate; and

9 “(cc) whether there are changes in the  
10 needs or status of the eligible individual,  
11 and if so, making necessary adjustments in  
12 the care plan and service arrangements  
13 with providers.

14 “(iii) Such term does not include the direct de-  
15 livery of an underlying medical, educational, social,  
16 or other service to which an eligible individual has  
17 been referred, including, with respect to the direct  
18 delivery of foster care services, services such as (but  
19 not limited to) the following:

20 “(I) Research gathering and completion of  
21 documentation required by the foster care pro-  
22 gram.

23 “(II) Assessing adoption placements.

24 “(III) Recruiting or interviewing potential  
25 foster care parents.



1 “(IV) Serving legal papers.

2 “(V) Home investigations.

3 “(VI) Providing transportation.

4 “(VII) Administering foster care subsidies.

5 “(VIII) Making placement arrangements.

6 “(B) The term ‘targeted case management serv-  
7 ices’ are case management services that are fur-  
8 nished without regard to the requirements of section  
9 1902(a)(1) and section 1902(a)(10)(B) to specific  
10 classes of individuals or to individuals who reside in  
11 specified areas.

12 “(3) With respect to contacts with individuals who  
13 are not eligible for medical assistance under the State plan  
14 or, in the case of targeted case management services, indi-  
15 viduals who are eligible for such assistance but are not  
16 part of the target population specified in the State plan,  
17 such contacts—

18 “(A) are considered an allowable case manage-  
19 ment activity, when the purpose of the contact is di-  
20 rectly related to the management of the eligible indi-  
21 vidual’s care; and

22 “(B) are not considered an allowable case man-  
23 agement activity if such contacts relate directly to  
24 the identification and management of the noneligible  
25 or nontargeted individual’s needs and care.

1       “(4)(A) In accordance with section 1902(a)(25), Fed-  
2 eral financial participation only is available under this title  
3 for case management services or targeted case manage-  
4 ment services if there are no other third parties liable to  
5 pay for such services, including as reimbursement under  
6 a medical, social, educational, or other program.

7       “(B) A State shall allocate the costs of any part of  
8 such services which are reimbursable under another feder-  
9 ally funded program in accordance with OMB Circular A-  
10 87 (or any related or successor guidance or regulations  
11 regarding allocation of costs among federally funded pro-  
12 grams) under an approved cost allocation program.

13       “(5) Nothing in this subsection shall be construed as  
14 affecting the application of rules with respect to third  
15 party liability under programs, or activities carried out  
16 under title XXVI of the Public Health Service Act or by  
17 the Indian Health Service.”.

18       (b) REGULATIONS.—The Secretary shall promulgate  
19 regulations to carry out the amendment made by sub-  
20 section (a) which may be effective and final immediately  
21 on an interim basis as of the date of publication of the  
22 interim final regulation. If the Secretary provides for an  
23 interim final regulation, the Secretary shall provide for a  
24 period of public comments on such regulation after the  
25 date of publication. The Secretary may change or revise

1 such regulation after completion of the period of public  
2 comment.

3 (c) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall take effect on January 1, 2006.

5 **SEC. 6053. ADDITIONAL FMAP ADJUSTMENTS.**

6 (a) HOLD HARMLESS FOR CERTAIN DECREASE.—  
7 Notwithstanding the first sentence of section 1905(b) of  
8 the Social Security Act (42 U.S.C. 1396d(b)), if, for pur-  
9 poses of titles XIX and XXI of the Social Security Act  
10 (42 U.S.C. 1396 et seq., 1397aa et seq.), the Federal med-  
11 ical assistance percentage determined for the State speci-  
12 fied in section 4725(a) of Public Law 105-33 for fiscal  
13 year 2006 or fiscal year 2007 is less than the Federal  
14 medical assistance percentage determined for such State  
15 for fiscal year 2005, the Federal medical assistance per-  
16 centage determined for such State for fiscal year 2005  
17 shall be substituted for the Federal medical assistance  
18 percentage otherwise determined for such State for fiscal  
19 year 2006 or fiscal year 2007, as the case may be.

20 (b) HOLD HARMLESS FOR KATRINA IMPACT.—Not-  
21 withstanding any other provision of law, for purposes of  
22 titles XIX and XXI of the Social Security Act, the Sec-  
23 retary of Health and Human Services, in computing the  
24 Federal medical assistance percentage under section  
25 1905(b) of such Act (42 U.S.C. 1396d(b)) for any year

1 after 2006 for a State that the Secretary determines has  
2 a significant number of evacuees who were evacuated to,  
3 and live in, the State as a result of Hurricane Katrina  
4 as of October 1, 2005, shall disregard such evacuees (and  
5 income attributable to such evacuees) from such computa-  
6 tion.

7 **SEC. 6054. DSH ALLOTMENT FOR THE DISTRICT OF COLUM-**  
8 **BIA.**

9 (a) IN GENERAL.—For purposes of determining the  
10 DSH allotment for the District of Columbia under section  
11 1923 of the Social Security Act (42 U.S.C. 1396r–4) for  
12 fiscal year 2006 and each subsequent fiscal year, the table  
13 in subsection (f)(2) of such section is amended under each  
14 of the columns for FY 00, FY 01, and FY 02, in the entry  
15 for the District of Columbia by striking “32” and insert-  
16 ing “49”.

17 (b) EFFECTIVE DATE.—The amendments made by  
18 subsection (a) shall take effect as if enacted on October  
19 1, 2005, and shall only apply to disproportionate share  
20 hospital adjustment expenditures applicable to fiscal year  
21 2006 and subsequent fiscal years made on or after that  
22 date.

1   **SEC. 6055. INCREASE IN MEDICAID PAYMENTS TO INSULAR**  
2                   **AREAS.**

3           Section 1108(g) of the Social Security Act (42 U.S.C.  
4   1308(g)) is amended—

5           (1) in paragraph (2), by inserting “and subject  
6   to paragraph (3)” after “subsection (f)”; and

7           (2) by adding at the end the following new  
8   paragraph:

9           “(3) FISCAL YEARS 2006 AND 2007 FOR CERTAIN  
10   INSULAR AREAS.—The amounts otherwise deter-  
11   mined under this subsection for Puerto Rico, the  
12   Virgin Islands, Guam, the Northern Mariana Is-  
13   lands, and American Samoa for fiscal year 2006 and  
14   fiscal year 2007 shall be increased by the following  
15   amounts:

16           “(A) For Puerto Rico, \$12,000,000 for fis-  
17   cal year 2006 and \$12,000,000 for fiscal year  
18   2007.

19           “(B) For the Virgin Islands, \$2,500,000  
20   for fiscal year 2006 and \$5,000,000 for fiscal  
21   year 2007.

22           “(C) For Guam, \$2,500,000 for fiscal year  
23   2006 and \$5,000,000 for fiscal year 2007.

24           “(D) For the Northern Mariana Islands,  
25   \$1,000,000 for fiscal year 2006 and \$2,000,000  
26   for fiscal year 2007.

1           “(E) For American Samoa, \$2,000,000 for  
2           fiscal year 2006 and \$4,000,000 for fiscal year  
3           2007.

4           Such amounts shall not be taken into account in ap-  
5           plying paragraph (2) for fiscal year 2007 but shall  
6           be taken into account in applying such paragraph  
7           for fiscal year 2008 and subsequent fiscal years.”.

## 8           **CHAPTER 6—OTHER PROVISIONS**

### 9           **Subchapter A—Family Opportunity Act**

#### 10       **SEC. 6061. SHORT TITLE OF SUBCHAPTER.**

11           This subchapter may be cited as the “Family Oppor-  
12       tunity Act of 2005” or the “Dylan Lee James Act”.

#### 13       **SEC. 6062. OPPORTUNITY FOR FAMILIES OF DISABLED** 14               **CHILDREN TO PURCHASE MEDICAID COV-** 15               **ERAGE FOR SUCH CHILDREN.**

16           (a) STATE OPTION TO ALLOW FAMILIES OF DIS-  
17       ABLED CHILDREN TO PURCHASE MEDICAID COVERAGE  
18       FOR SUCH CHILDREN.—

19               (1) IN GENERAL.—Section 1902 of the Social  
20       Security Act (42 U.S.C. 1396a) is amended—

21                       (A) in subsection (a)(10)(A)(ii)—

22                               (i) by striking “or” at the end of sub-  
23                       clause (XVII);

24                               (ii) by adding “or” at the end of sub-  
25                       clause (XVIII); and

1 (iii) by adding at the end the fol-  
2 lowing new subclause:

3 “(XIX) who are disabled children  
4 described in subsection (cc)(1);” and  
5 (B) by adding at the end the following new  
6 subsection:

7 “(cc)(1) Individuals described in this paragraph are  
8 individuals—

9 “(A) who are children who have not attained 19  
10 years of age and are born—

11 “(i) on or after January 1, 2001 (or, at  
12 the option of a State, on or after an earlier  
13 date), in the case of the second, third, and  
14 fourth quarters of fiscal year 2007;

15 “(ii) on or after October 1, 1995 (or, at  
16 the option of a State, on or after an earlier  
17 date), in the case of each quarter of fiscal year  
18 2008; and

19 “(iii) after October 1, 1989, in the case of  
20 each quarter of fiscal year 2009 and each quar-  
21 ter of any fiscal year thereafter;

22 “(B) who would be considered disabled under  
23 section 1614(a)(3)(C) (as determined under title  
24 XVI for children but without regard to any income

1 or asset eligibility requirements that apply under  
2 such title with respect to children); and

3 “(C) whose family income does not exceed such  
4 income level as the State establishes and does not  
5 exceed—

6 “(i) 300 percent of the poverty line (as de-  
7 fined in section 2110(c)(5)) applicable to a fam-  
8 ily of the size involved; or

9 “(ii) such higher percent of such poverty  
10 line as a State may establish, except that—

11 “(I) any medical assistance provided  
12 to an individual whose family income ex-  
13 ceeds 300 percent of such poverty line may  
14 only be provided with State funds; and

15 “(II) no Federal financial participa-  
16 tion shall be provided under section  
17 1903(a) for any medical assistance pro-  
18 vided to such an individual.”.

19 (2) INTERACTION WITH EMPLOYER-SPONSORED  
20 FAMILY COVERAGE.—Section 1902(cc) of such Act  
21 (42 U.S.C. 1396a(cc)), as added by paragraph  
22 (1)(B), is amended by adding at the end the fol-  
23 lowing new paragraph:

24 “(2)(A) If an employer of a parent of an individual  
25 described in paragraph (1) offers family coverage under



1 a group health plan (as defined in section 2791(a) of the  
2 Public Health Service Act), the State shall—

3 “(i) notwithstanding section 1906, require such  
4 parent to apply for, enroll in, and pay premiums for  
5 such coverage as a condition of such parent’s child  
6 being or remaining eligible for medical assistance  
7 under subsection (a)(10)(A)(ii)(XIX) if the parent is  
8 determined eligible for such coverage and the em-  
9 ployer contributes at least 50 percent of the total  
10 cost of annual premiums for such coverage; and

11 “(ii) if such coverage is obtained—

12 “(I) subject to paragraph (2) of section  
13 1916(h), reduce the premium imposed by the  
14 State under that section in an amount that rea-  
15 sonably reflects the premium contribution made  
16 by the parent for private coverage on behalf of  
17 a child with a disability; and

18 “(II) treat such coverage as a third party  
19 liability under subsection (a)(25).

20 “(B) In the case of a parent to which subparagraph  
21 (A) applies, a State, notwithstanding section 1906 but  
22 subject to paragraph (1)(C)(ii), may provide for payment  
23 of any portion of the annual premium for such family cov-  
24 erage that the parent is required to pay. Any payments  
25 made by the State under this subparagraph shall be con-

1 sidered, for purposes of section 1903(a), to be payments  
2 for medical assistance.”.

3 (b) STATE OPTION TO IMPOSE INCOME-RELATED  
4 PREMIUMS.—Section 1916 of such Act (42 U.S.C. 1396o)  
5 is amended—

6 (1) in subsection (a), by striking “subsection  
7 (g)” and inserting “subsections (g) and (i)”; and

8 (2) by adding at the end, as amended by section  
9 6041(b)(2), the following new subsection:

10 “(i)(1) With respect to disabled children provided  
11 medical assistance under section 1902(a)(10)(A)(ii)(XIX),  
12 subject to paragraph (2), a State may (in a uniform man-  
13 ner for such children) require the families of such children  
14 to pay monthly premiums set on a sliding scale based on  
15 family income.

16 “(2) A premium requirement imposed under para-  
17 graph (1) may only apply to the extent that—

18 “(A) in the case of a disabled child described in  
19 that paragraph whose family income—

20 “(i) does not exceed 200 percent of the  
21 poverty line, the aggregate amount of such pre-  
22 mium and any premium that the parent is re-  
23 quired to pay for family coverage under section  
24 1902(cc)(2)(A)(i) and other cost-sharing

1 charges do not exceed 5 percent of the family's  
2 income; and

3 “(ii) exceeds 200, but does not exceed 300,  
4 percent of the poverty line, the aggregate  
5 amount of such premium and any premium that  
6 the parent is required to pay for family cov-  
7 erage under section 1902(cc)(2)(A)(i) and other  
8 cost-sharing charges do not exceed 7.5 percent  
9 of the family's income; and

10 “(B) the requirement is imposed consistent with  
11 section 1902(cc)(2)(A)(ii)(I).

12 “(3) A State shall not require prepayment of a pre-  
13 mium imposed pursuant to paragraph (1) and shall not  
14 terminate eligibility of a child under section  
15 1902(a)(10)(A)(ii)(XIX) for medical assistance under this  
16 title on the basis of failure to pay any such premium until  
17 such failure continues for a period of at least 60 days from  
18 the date on which the premium became past due. The  
19 State may waive payment of any such premium in any  
20 case where the State determines that requiring such pay-  
21 ment would create an undue hardship.”.

22 (c) CONFORMING AMENDMENTS.—(1) Section  
23 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amend-  
24 ed in the matter preceding subparagraph (A), by inserting

1 “1902(a)(10)(A)(ii)(XIX),” after  
2 “1902(a)(10)(A)(ii)(XVIII),”.

3 (2) Section 1905(u)(2)(B) of such Act (42 U.S.C.  
4 1396d(u)(2)(B)) is amended by adding at the end the fol-  
5 lowing sentence: “Such term excludes any child eligible for  
6 medical assistance only by reason of section  
7 1902(a)(10)(A)(ii)(XIX).”.

8 (d) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to medical assistance for items and  
10 services furnished on or after January 1, 2007.

11 **SEC. 6063. DEMONSTRATION PROJECTS REGARDING HOME**  
12 **AND COMMUNITY-BASED ALTERNATIVES TO**  
13 **PSYCHIATRIC RESIDENTIAL TREATMENT FA-**  
14 **CILITIES FOR CHILDREN.**

15 (a) IN GENERAL.—The Secretary is authorized to  
16 conduct, during each of fiscal years 2007 through 2011,  
17 demonstration projects (each in the section referred to as  
18 a “demonstration project”) in accordance with this section  
19 under which up to 10 States (as defined for purposes of  
20 title XIX of the Social Security Act) are awarded grants,  
21 on a competitive basis, to test the effectiveness in improv-  
22 ing or maintaining a child’s functional level and cost-effec-  
23 tiveness of providing coverage of home and community-  
24 based alternatives to psychiatric residential treatment for

1 children enrolled in the Medicaid program under title XIX  
2 of such Act.

3 (b) APPLICATION OF TERMS AND CONDITIONS.—

4 (1) IN GENERAL.—Subject to the provisions of  
5 this section, for the purposes of the demonstration  
6 projects, and only with respect to children enrolled  
7 under such demonstration projects, a psychiatric res-  
8 idential treatment facility (as defined in section  
9 483.352 of title 42 of the Code of Federal Regula-  
10 tions) shall be deemed to be a facility specified in  
11 section 1915(c) of the Social Security Act (42  
12 U.S.C. 1396n(c)), and to be included in each ref-  
13 erence in such section 1915(c) to hospitals, nursing  
14 facilities, and intermediate care facilities for the  
15 mentally retarded.

16 (2) STATE OPTION TO ASSURE CONTINUITY OF  
17 MEDICAID COVERAGE.—Upon the termination of a  
18 demonstration project under this section, the State  
19 that conducted the project may elect, only with re-  
20 spect to a child who is enrolled in such project on  
21 the termination date, to continue to provide medical  
22 assistance for coverage of home and community-  
23 based alternatives to psychiatric residential treat-  
24 ment for the child in accordance with section  
25 1915(c) of the Social Security Act (42 U.S.C.

1       1396n(c)), as modified through the application of  
2       paragraph (1). Expenditures incurred for providing  
3       such medical assistance shall be treated as a home  
4       and community-based waiver program under section  
5       1915(c) of the Social Security Act (42 U.S.C.  
6       1396n(c)) for purposes of payment under section  
7       1903 of such Act (42 U.S.C. 1396b).

8       (c) TERMS OF DEMONSTRATION PROJECTS.—

9           (1) IN GENERAL.—Except as otherwise pro-  
10       vided in this section, a demonstration project shall  
11       be subject to the same terms and conditions as apply  
12       to a waiver under section 1915(c) of the Social Se-  
13       curity Act (42 U.S.C. 1396n(c)), including the waiv-  
14       er of certain requirements under the first sentence  
15       of paragraph (3) of such section but not applying  
16       the second sentence of such paragraph.

17          (2) BUDGET NEUTRALITY.—In conducting the  
18       demonstration projects under this section, the Sec-  
19       retary shall ensure that the aggregate payments  
20       made by the Secretary under title XIX of the Social  
21       Security Act (42 U.S.C. 1396 et seq.) do not exceed  
22       the amount which the Secretary estimates would  
23       have been paid under that title if the demonstration  
24       projects under this section had not been imple-  
25       mented.

1           (3) EVALUATION.—The application for a dem-  
2           onstration project shall include an assurance to pro-  
3           vide for such interim and final evaluations of the  
4           demonstration project by independent third parties,  
5           and for such interim and final reports to the Sec-  
6           retary, as the Secretary may require.

7           (d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE  
8           AND FUNDING.—

9           (1) IN GENERAL.—Subject to paragraph (2), a  
10          demonstration project approved by the Secretary  
11          under this section shall be treated as a home and  
12          community-based waiver program under section  
13          1915(c) of the Social Security Act (42 U.S.C.  
14          1396n(c)) for purposes of payment under section  
15          1903 of such Act (42 U.S.C. 1396b).

16          (2) LIMITATION.—In no case may the amount  
17          of payments made by the Secretary under this sec-  
18          tion for State demonstration projects for a fiscal  
19          year exceed the amount available under subsection  
20          (f)(2)(A) for such fiscal year.

21          (e) SECRETARY'S EVALUATION AND REPORT.—The  
22          Secretary shall conduct an interim and final evaluation of  
23          State demonstration projects under this section and shall  
24          report to the President and Congress the conclusions of

1 such evaluations within 12 months of completing such  
2 evaluations.

3 (f) FUNDING.—

4 (1) IN GENERAL.—For the purpose of carrying  
5 out this section, there are appropriated, from  
6 amounts in the Treasury not otherwise appropriated,  
7 for fiscal years 2007 through 2011, a total of  
8 \$218,000,000, of which—

9 (A) the amount specified in paragraph (2)  
10 shall be available for each of fiscal years 2007  
11 through 2011; and

12 (B) a total of \$1,000,000 shall be available  
13 to the Secretary for the evaluations and report  
14 under subsection (e).

15 (2) FISCAL YEAR LIMIT.—

16 (A) IN GENERAL.—For purposes of para-  
17 graph (1), the amount specified in this para-  
18 graph for a fiscal year is the amount specified  
19 in subparagraph (B) for the fiscal year plus the  
20 difference, if any, between the total amount  
21 available under this paragraph for prior fiscal  
22 years and the total amount previously expended  
23 under paragraph (1)(A) for such prior fiscal  
24 years.



1 (B) FISCAL YEAR AMOUNTS.—The amount  
2 specified in this subparagraph for—

3 (i) fiscal year 2007 is \$21,000,000;

4 (ii) fiscal year 2008 is \$37,000,000;

5 (iii) fiscal year 2009 is \$49,000,000;

6 (iv) fiscal year 2010 is \$53,000,000;

7 and

8 (v) fiscal year 2011 is \$57,000,000.

9 **SEC. 6064. DEVELOPMENT AND SUPPORT OF FAMILY-TO-**  
10 **FAMILY HEALTH INFORMATION CENTERS.**

11 Section 501 of the Social Security Act (42 U.S.C.  
12 701) is amended by adding at the end the following new  
13 subsection:

14 “(c)(1)(A) For the purpose of enabling the Secretary  
15 (through grants, contracts, or otherwise) to provide for  
16 special projects of regional and national significance for  
17 the development and support of family-to-family health in-  
18 formation centers described in paragraph (2)—

19 “(i) there is appropriated to the Secretary, out  
20 of any money in the Treasury not otherwise  
21 appropriated—

22 “(I) \$3,000,000 for fiscal year 2007;

23 “(II) \$4,000,000 for fiscal year 2008; and

24 “(III) \$5,000,000 for fiscal year 2009; and

1           “(ii) there is authorized to be appropriated to  
2           the Secretary, \$5,000,000 for each of fiscal years  
3           2010 and 2011.

4           “(B) Funds appropriated or authorized to be appro-  
5           priated under subparagraph (A) shall—

6           “(i) be in addition to amounts appropriated  
7           under subsection (a) and retained under section  
8           502(a)(1) for the purpose of carrying out activities  
9           described in subsection (a)(2); and

10          “(ii) remain available until expended.

11          “(2) The family-to-family health information centers  
12          described in this paragraph are centers that—

13               “(A) assist families of children with disabilities  
14               or special health care needs to make informed  
15               choices about health care in order to promote good  
16               treatment decisions, cost-effectiveness, and improved  
17               health outcomes for such children;

18               “(B) provide information regarding the health  
19               care needs of, and resources available for, such chil-  
20               dren;

21               “(C) identify successful health delivery models  
22               for such children;

23               “(D) develop with representatives of health care  
24               providers, managed care organizations, health care  
25               purchasers, and appropriate State agencies, a model

1 for collaboration between families of such children  
2 and health professionals;

3 “(E) provide training and guidance regarding  
4 caring for such children;

5 “(F) conduct outreach activities to the families  
6 of such children, health professionals, schools, and  
7 other appropriate entities and individuals; and

8 “(G) are staffed—

9 “(i) by such families who have expertise in  
10 Federal and State public and private health  
11 care systems; and

12 “(ii) by health professionals.

13 “(3) The Secretary shall develop family-to-family  
14 health information centers described in paragraph (2) in  
15 accordance with the following:

16 “(A) With respect to fiscal year 2007, such cen-  
17 ters shall be developed in not less than 25 States.

18 “(B) With respect to fiscal year 2008, such  
19 centers shall be developed in not less than 40 States.

20 “(C) With respect to fiscal year 2009 and each  
21 fiscal year thereafter, such centers shall be developed  
22 in all States.

23 “(4) The provisions of this title that are applicable  
24 to the funds made available to the Secretary under section

1 502(a)(1) apply in the same manner to funds made avail-  
2 able to the Secretary under paragraph (1)(A).

3 “(5) For purposes of this subsection, the term ‘State’  
4 means each of the 50 States and the District of Colum-  
5 bia.”.

6 **SEC. 6065. RESTORATION OF MEDICAID ELIGIBILITY FOR**  
7 **CERTAIN SSI BENEFICIARIES.**

8 (a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) of  
9 the Social Security Act (42 U.S.C.  
10 1396a(a)(10)(A)(i)(II)) is amended—

11 (1) by inserting “(aa)” after “(II)”;

12 (2) by striking “) and” and inserting “and”;

13 (3) by striking “section or who are” and insert-  
14 ing “section), (bb) who are”; and

15 (4) by inserting before the comma at the end  
16 the following: “, or (cc) who are under 21 years of  
17 age and with respect to whom supplemental security  
18 income benefits would be paid under title XVI if  
19 subparagraphs (A) and (B) of section 1611(c)(7)  
20 were applied without regard to the phrase ‘the first  
21 day of the month following’ ”.

22 (b) EFFECTIVE DATE.—The amendments made by  
23 subsection (a) shall apply to medical assistance for items  
24 and services furnished on or after the date that is 1 year  
25 after the date of enactment of this Act.

1     **Subchapter B—Money Follows the Person**

2             **Rebalancing Demonstration**

3     **SEC. 6071. MONEY FOLLOWS THE PERSON REBALANCING**

4             **DEMONSTRATION.**

5             (a) PROGRAM PURPOSE AND AUTHORITY.—The Sec-  
6     retary is authorized to award, on a competitive basis,  
7     grants to States in accordance with this section for dem-  
8     onstration projects (each in this section referred to as an  
9     “MFP demonstration project”) designed to achieve the  
10    following objectives with respect to institutional and home  
11    and community-based long-term care services under State  
12    Medicaid programs:

13            (1) REBALANCING.—Increase the use of home  
14            and community-based, rather than institutional,  
15            long-term care services.

16            (2) MONEY FOLLOWS THE PERSON.—Eliminate  
17            barriers or mechanisms, whether in the State law,  
18            the State Medicaid plan, the State budget, or other-  
19            wise, that prevent or restrict the flexible use of Med-  
20            icaid funds to enable Medicaid-eligible individuals to  
21            receive support for appropriate and necessary long-  
22            term services in the settings of their choice.

23            (3) CONTINUITY OF SERVICE.—Increase the  
24            ability of the State Medicaid program to assure con-  
25            tinued provision of home and community-based long-

1 term care services to eligible individuals who choose  
2 to transition from an institutional to a community  
3 setting.

4 (4) QUALITY ASSURANCE AND QUALITY IM-  
5 PROVEMENT.—Ensure that procedures are in place  
6 (at least comparable to those required under the  
7 qualified HCB program) to provide quality assur-  
8 ance for eligible individuals receiving Medicaid home  
9 and community-based long-term care services and to  
10 provide for continuous quality improvement in such  
11 services.

12 (b) DEFINITIONS.—For purposes of this section:

13 (1) HOME AND COMMUNITY-BASED LONG-TERM  
14 CARE SERVICES.—The term “home and community-  
15 based long-term care services” means, with respect  
16 to a State Medicaid program, home and community-  
17 based services (including home health and personal  
18 care services) that are provided under the State’s  
19 qualified HCB program or that could be provided  
20 under such a program but are otherwise provided  
21 under the Medicaid program.

22 (2) ELIGIBLE INDIVIDUAL.—The term “eligible  
23 individual” means, with respect to an MFP dem-  
24 onstration project of a State, an individual in the  
25 State—

1 (A) who, immediately before beginning  
2 participation in the MFP demonstration  
3 project—

4 (i) resides (and has resided, for a pe-  
5 riod of not less than 6 months or for such  
6 longer minimum period, not to exceed 2  
7 years, as may be specified by the State) in  
8 an inpatient facility;

9 (ii) is receiving Medicaid benefits for  
10 inpatient services furnished by such inpa-  
11 tient facility; and

12 (iii) with respect to whom a deter-  
13 mination has been made that, but for the  
14 provision of home and community-based  
15 long-term care services, the individual  
16 would continue to require the level of care  
17 provided in an inpatient facility and, in  
18 any case in which the State applies a more  
19 stringent level of care standard as a result  
20 of implementing the State plan option per-  
21 mitted under section 1915(i) of the Social  
22 Security Act, the individual must continue  
23 to require at least the level of care which  
24 had resulted in admission to the institu-  
25 tion; and

1 (B) who resides in a qualified residence be-  
2 ginning on the initial date of participation in  
3 the demonstration project.

4 (3) INPATIENT FACILITY.—The term “inpatient  
5 facility” means a hospital, nursing facility, or inter-  
6 mediate care facility for the mentally retarded. Such  
7 term includes an institution for mental diseases, but  
8 only, with respect to a State, to the extent medical  
9 assistance is available under the State Medicaid plan  
10 for services provided by such institution.

11 (4) MEDICAID.—The term “Medicaid” means,  
12 with respect to a State, the State program under  
13 title XIX of the Social Security Act (including any  
14 waiver or demonstration under such title or under  
15 section 1115 of such Act relating to such title).

16 (5) QUALIFIED HCB PROGRAM.—The term  
17 “qualified HCB program” means a program pro-  
18 viding home and community-based long-term care  
19 services operating under Medicaid, whether or not  
20 operating under waiver authority.

21 (6) QUALIFIED RESIDENCE.—The term “quali-  
22 fied residence” means, with respect to an eligible  
23 individual—

24 (A) a home owned or leased by the indi-  
25 vidual or the individual’s family member;



1 (B) an apartment with an individual lease,  
2 with lockable access and egress, and which in-  
3 cludes living, sleeping, bathing, and cooking  
4 areas over which the individual or the individ-  
5 ual's family has domain and control; and

6 (C) a residence, in a community-based res-  
7 idential setting, in which no more than 4 unre-  
8 lated individuals reside.

9 (7) QUALIFIED EXPENDITURES.—The term  
10 “qualified expenditures” means expenditures by the  
11 State under its MFP demonstration project for  
12 home and community-based long-term care services  
13 for an eligible individual participating in the MFP  
14 demonstration project, but only with respect to serv-  
15 ices furnished during the 12-month period beginning  
16 on the date the individual is discharged from an in-  
17 patient facility referred to in paragraph (2)(A)(i).

18 (8) SELF-DIRECTED SERVICES.—The term  
19 “self-directed” means, with respect to home and  
20 community-based long-term care services for an eli-  
21 gible individual, such services for the individual  
22 which are planned and purchased under the direc-  
23 tion and control of such individual or the individ-  
24 ual's authorized representative (as defined by the  
25 Secretary), including the amount, duration, scope,

1 provider, and location of such services, under the  
2 State Medicaid program consistent with the fol-  
3 lowing requirements:

4 (A) ASSESSMENT.—There is an assess-  
5 ment of the needs, capabilities, and preferences  
6 of the individual with respect to such services.

7 (B) SERVICE PLAN.—Based on such as-  
8 sessment, there is developed jointly with such  
9 individual or the individual's authorized rep-  
10 resentative a plan for such services for such in-  
11 dividual that is approved by the State and  
12 that—

13 (i) specifies those services, if any,  
14 which the individual or the individual's au-  
15 thorized representative would be respon-  
16 sible for directing;

17 (ii) identifies the methods by which  
18 the individual or the individual's author-  
19 ized representative or an agency designated  
20 by an individual or representative will se-  
21 lect, manage, and dismiss providers of such  
22 services;

23 (iii) specifies the role of family mem-  
24 bers and others whose participation is  
25 sought by the individual or the individual's

1 authorized representative with respect to  
2 such services;

3 (iv) is developed through a person-  
4 centered process that—

5 (I) is directed by the individual  
6 or the individual's authorized rep-  
7 resentative;

8 (II) builds upon the individual's  
9 capacity to engage in activities that  
10 promote community life and that re-  
11 spects the individual's preferences,  
12 choices, and abilities; and

13 (III) involves families, friends,  
14 and professionals as desired or re-  
15 quired by the individual or the indi-  
16 vidual's authorized representative;

17 (v) includes appropriate risk manage-  
18 ment techniques that recognize the roles  
19 and sharing of responsibilities in obtaining  
20 services in a self-directed manner and as-  
21 sure the appropriateness of such plan  
22 based upon the resources and capabilities  
23 of the individual or the individual's author-  
24 ized representative; and

1                   (vi) may include an individualized  
2                   budget which identifies the dollar value of  
3                   the services and supports under the control  
4                   and direction of the individual or the indi-  
5                   vidual's authorized representative.

6                   (C) BUDGET PROCESS.—With respect to  
7                   individualized budgets described in subpara-  
8                   graph (B)(vi), the State application under sub-  
9                   section (c)—

10                   (i) describes the method for calcu-  
11                   lating the dollar values in such budgets  
12                   based on reliable costs and service utiliza-  
13                   tion;

14                   (ii) defines a process for making ad-  
15                   justments in such dollar values to reflect  
16                   changes in individual assessments and  
17                   service plans; and

18                   (iii) provides a procedure to evaluate  
19                   expenditures under such budgets.

20                   (9) STATE.—The term “State” has the mean-  
21                   ing given such term for purposes of title XIX of the  
22                   Social Security Act.

23                   (c) STATE APPLICATION.—A State seeking approval  
24                   of an MFP demonstration project shall submit to the Sec-  
25                   retary, at such time and in such format as the Secretary

1 requires, an application meeting the following require-  
2 ments and containing such additional information, provi-  
3 sions, and assurances, as the Secretary may require:

4           (1) ASSURANCE OF A PUBLIC DEVELOPMENT  
5       PROCESS.—The application contains an assurance  
6       that the State has engaged, and will continue to en-  
7       gage, in a public process for the design, develop-  
8       ment, and evaluation of the MFP demonstration  
9       project that allows for input from eligible individ-  
10      uals, the families of such individuals, authorized rep-  
11      resentatives of such individuals, providers, and other  
12      interested parties.

13           (2) OPERATION IN CONNECTION WITH QUALI-  
14      FIED HCB PROGRAM TO ASSURE CONTINUITY OF  
15      SERVICES.—The State will conduct the MFP dem-  
16      onstration project for eligible individuals in conjunc-  
17      tion with the operation of a qualified HCB program  
18      that is in operation (or approved) in the State for  
19      such individuals in a manner that assures continuity  
20      of Medicaid coverage for such individuals so long as  
21      such individuals continue to be eligible for medical  
22      assistance.

23           (3) DEMONSTRATION PROJECT PERIOD.—The  
24      application shall specify the period of the MFP dem-  
25      onstration project, which shall include at least 2 con-

1       secutive fiscal years in the 5-fiscal-year period begin-  
2       ning with fiscal year 2007.

3           (4) SERVICE AREA.—The application shall  
4       specify the service area or areas of the MFP dem-  
5       onstration project, which may be a statewide area or  
6       1 or more geographic areas of the State.

7           (5) TARGETED GROUPS AND NUMBERS OF INDIV-  
8       VIDUALS SERVED.—The application shall specify—

9           (A) the target groups of eligible individuals  
10       to be assisted to transition from an inpatient  
11       facility to a qualified residence during each fis-  
12       cal year of the MFP demonstration project;

13          (B) the projected numbers of eligible indi-  
14       viduals in each targeted group of eligible indi-  
15       viduals to be so assisted during each such year;  
16       and

17          (C) the estimated total annual qualified ex-  
18       penditures for each fiscal year of the MFP  
19       demonstration project.

20          (6) INDIVIDUAL CHOICE, CONTINUITY OF  
21       CARE.—The application shall contain assurances  
22       that—

23           (A) each eligible individual or the individ-  
24       ual's authorized representative will be provided  
25       the opportunity to make an informed choice re-

1           garding whether to participate in the MFP  
2           demonstration project;

3                 (B) each eligible individual or the individ-  
4           ual's authorized representative will choose the  
5           qualified residence in which the individual will  
6           reside and the setting in which the individual  
7           will receive home and community-based long-  
8           term care services;

9                 (C) the State will continue to make avail-  
10          able, so long as the State operates its qualified  
11          HCB program consistent with applicable re-  
12          quirements, home and community-based long-  
13          term care services to each individual who com-  
14          pletes participation in the MFP demonstration  
15          project for as long as the individual remains eli-  
16          gible for medical assistance for such services  
17          under such qualified HCB program (including  
18          meeting a requirement relating to requiring a  
19          level of care provided in an inpatient facility  
20          and continuing to require such services, and, if  
21          the State applies a more stringent level of care  
22          standard as a result of implementing the State  
23          plan option permitted under section 1915(i) of  
24          the Social Security Act, meeting the require-  
25          ment for at least the level of care which had re-

1           sulted in the individual's admission to the insti-  
2           tution).

3           (7) REBALANCING.—The application shall—

4                   (A) provide such information as the Sec-  
5           retary may require concerning the dollar  
6           amounts of State Medicaid expenditures for the  
7           fiscal year, immediately preceding the first fis-  
8           cal year of the State's MFP demonstration  
9           project, for long-term care services and the per-  
10          centage of such expenditures that were for in-  
11          stitutional long-term care services or were for  
12          home and community-based long-term care  
13          services;

14                   (B)(i) specify the methods to be used by  
15          the State to increase, for each fiscal year dur-  
16          ing the MFP demonstration project, the dollar  
17          amount of such total expenditures for home and  
18          community-based long-term care services and  
19          the percentage of such total expenditures for  
20          long-term care services that are for home and  
21          community-based long-term care services; and

22                   (ii) describe the extent to which the MFP  
23          demonstration project will contribute to accom-  
24          plishment of objectives described in subsection  
25          (a).



1           (8) MONEY FOLLOWS THE PERSON.—The appli-  
2           cation shall describe the methods to be used by the  
3           State to eliminate any legal, budgetary, or other bar-  
4           riers to flexibility in the availability of Medicaid  
5           funds to pay for long-term care services for eligible  
6           individuals participating in the project in the appro-  
7           priate settings of their choice, including costs to  
8           transition from an institutional setting to a qualified  
9           residence.

10          (9) MAINTENANCE OF EFFORT AND COST-EF-  
11          FECTIVENESS.—The application shall contain or be  
12          accompanied by such information and assurances as  
13          may be required to satisfy the Secretary that—

14                (A) total expenditures under the State  
15                Medicaid program for home and community-  
16                based long-term care services will not be less  
17                for any fiscal year during the MFP demonstra-  
18                tion project than for the greater of such ex-  
19                penditures for—

20                       (i) fiscal year 2005; or

21                       (ii) any succeeding fiscal year before  
22                       the first year of the MFP demonstration  
23                       project; and

24                (B) in the case of a qualified HCB pro-  
25                gram operating under a waiver under sub-

1 section (c) or (d) of section 1915 of the Social  
2 Security Act (42 U.S.C. 1396n), but for the  
3 amount awarded under a grant under this sec-  
4 tion, the State program would continue to meet  
5 the cost-effectiveness requirements of subsection  
6 (c)(2)(D) of such section or comparable require-  
7 ments under subsection (d)(5) of such section,  
8 respectively.

9 (10) WAIVER REQUESTS.—The application shall  
10 contain or be accompanied by requests for any modi-  
11 fication or adjustment of waivers of Medicaid re-  
12 quirements described in subsection (d)(3), including  
13 adjustments to the maximum numbers of individuals  
14 included and package of benefits, including one-time  
15 transitional services, provided.

16 (11) QUALITY ASSURANCE AND QUALITY IM-  
17 PROVEMENT.—The application shall include—

18 (A) a plan satisfactory to the Secretary for  
19 quality assurance and quality improvement for  
20 home and community-based long-term care  
21 services under the State Medicaid program, in-  
22 cluding a plan to assure the health and welfare  
23 of individuals participating in the MFP dem-  
24 onstration project; and

1 (B) an assurance that the State will co-  
2 operate in carrying out activities under sub-  
3 section (f) to develop and implement continuous  
4 quality assurance and quality improvement sys-  
5 tems for home and community-based long-term  
6 care services.

7 (12) OPTIONAL PROGRAM FOR SELF-DIRECTED  
8 SERVICES.—If the State elects to provide for any  
9 home and community-based long-term care services  
10 as self-directed services (as defined in subsection  
11 (b)(8)) under the MFP demonstration project, the  
12 application shall provide the following:

13 (A) MEETING REQUIREMENTS.—A descrip-  
14 tion of how the project will meet the applicable  
15 requirements of such subsection for the provi-  
16 sion of self-directed services.

17 (B) VOLUNTARY ELECTION.—A description  
18 of how eligible individuals will be provided with  
19 the opportunity to make an informed election to  
20 receive self-directed services under the project  
21 and after the end of the project.

22 (C) STATE SUPPORT IN SERVICE PLAN DE-  
23 VELOPMENT.—Satisfactory assurances that the  
24 State will provide support to eligible individuals

1           who self-direct in developing and implementing  
2           their service plans.

3                   (D) OVERSIGHT OF RECEIPT OF SERV-  
4           ICES.—Satisfactory assurances that the State  
5           will provide oversight of eligible individual's re-  
6           ceipt of such self-directed services, including  
7           steps to assure the quality of services provided  
8           and that the provision of such services are con-  
9           sistent with the service plan under such sub-  
10          section.

11          Nothing in this section shall be construed as requir-  
12          ing a State to make an election under the project to  
13          provide for home and community-based long-term  
14          care services as self-directed services, or as requiring  
15          an individual to elect to receive self-directed services  
16          under the project.

17                   (13) REPORTS AND EVALUATION.—The applica-  
18          tion shall provide that—

19                   (A) the State will furnish to the Secretary  
20          such reports concerning the MFP demonstra-  
21          tion project, on such timetable, in such uniform  
22          format, and containing such information as the  
23          Secretary may require, as will allow for reliable  
24          comparisons of MFP demonstration projects  
25          across States; and

1 (B) the State will participate in and co-  
2 operate with the evaluation of the MFP dem-  
3 onstration project.

4 (d) SECRETARY'S AWARD OF COMPETITIVE  
5 GRANTS.—

6 (1) IN GENERAL.—The Secretary shall award  
7 grants under this section on a competitive basis to  
8 States selected from among those with applications  
9 meeting the requirements of subsection (c), in ac-  
10 cordance with the provisions of this subsection.

11 (2) SELECTION AND MODIFICATION OF STATE  
12 APPLICATIONS.—In selecting State applications for  
13 the awarding of such a grant, the Secretary—

14 (A) shall take into consideration the man-  
15 ner in which, and extent to which, the State  
16 proposes to achieve the objectives specified in  
17 subsection (a);

18 (B) shall seek to achieve an appropriate  
19 national balance in the numbers of eligible indi-  
20 viduals, within different target groups of eligi-  
21 ble individuals, who are assisted to transition to  
22 qualified residences under MFP demonstration  
23 projects, and in the geographic distribution of  
24 States operating MFP demonstration projects;

1 (C) shall give preference to State applica-  
2 tions proposing—

3 (i) to provide transition assistance to  
4 eligible individuals within multiple target  
5 groups; and

6 (ii) to provide eligible individuals with  
7 the opportunity to receive home and com-  
8 munity-based long-term care services as  
9 self-directed services, as defined in sub-  
10 section (b)(8); and

11 (D) shall take such objectives into consid-  
12 eration in setting the annual amounts of State  
13 grant awards under this section.

14 (3) WAIVER AUTHORITY.—The Secretary is au-  
15 thorized to waive the following provisions of title  
16 XIX of the Social Security Act, to the extent nec-  
17 essary to enable a State initiative to meet the re-  
18 quirements and accomplish the purposes of this sec-  
19 tion:

20 (A) STATEWIDENESS.—Section  
21 1902(a)(1), in order to permit implementation  
22 of a State initiative in a selected area or areas  
23 of the State.

24 (B) COMPARABILITY.—Section  
25 1902(a)(10)(B), in order to permit a State ini-

1           tiative to assist a selected category or categories  
2           of individuals described in subsection (b)(2)(A).

3           (C) INCOME AND RESOURCES ELIGI-  
4           BILITY.—Section 1902(a)(10)(C)(i)(III), in  
5           order to permit a State to apply institutional  
6           eligibility rules to individuals transitioning to  
7           community-based care.

8           (D) PROVIDER AGREEMENTS.—Section  
9           1902(a)(27), in order to permit a State to im-  
10          plement self-directed services in a cost-effective  
11          manner.

12          (4) CONDITIONAL APPROVAL OF OUTYEAR  
13          GRANT.—In awarding grants under this section, the  
14          Secretary shall condition the grant for the second  
15          and any subsequent fiscal years of the grant period  
16          on the following:

17               (A) NUMERICAL BENCHMARKS.—The  
18               State must demonstrate to the satisfaction of  
19               the Secretary that it is meeting numerical  
20               benchmarks specified in the grant agreement  
21               for—

22                       (i) increasing State Medicaid support  
23                       for home and community-based long-term  
24                       care services under subsection (c)(5); and

1 (ii) numbers of eligible individuals as-  
2 sisted to transition to qualified residences.

3 (B) QUALITY OF CARE.—The State must  
4 demonstrate to the satisfaction of the Secretary  
5 that it is meeting the requirements under sub-  
6 section (c)(11) to assure the health and welfare  
7 of MFP demonstration project participants.

8 (e) PAYMENTS TO STATES; CARRYOVER OF UNUSED  
9 GRANT AMOUNTS.—

10 (1) PAYMENTS.—For each calendar quarter in  
11 a fiscal year during the period a State is awarded  
12 a grant under subsection (d), the Secretary shall pay  
13 to the State from its grant award for such fiscal  
14 year an amount equal to the lesser of—

15 (A) the MFP-enhanced FMAP (as defined  
16 in paragraph (5)) of the amount of qualified ex-  
17 penditures made during such quarter; or

18 (B) the total amount remaining in such  
19 grant award for such fiscal year (taking into  
20 account the application of paragraph (2)).

21 (2) CARRYOVER OF UNUSED AMOUNTS.—Any  
22 portion of a State grant award for a fiscal year  
23 under this section remaining at the end of such fis-  
24 cal year shall remain available to the State for the  
25 next 4 fiscal years, subject to paragraph (3).



1           (3) REAWARDING OF CERTAIN UNUSED  
2 AMOUNTS.—In the case of a State that the Sec-  
3 retary determines pursuant to subsection (d)(4) has  
4 failed to meet the conditions for continuation of a  
5 MFP demonstration project under this section in a  
6 succeeding year or years, the Secretary shall rescind  
7 the grant awards for such succeeding year or years,  
8 together with any unspent portion of an award for  
9 prior years, and shall add such amounts to the ap-  
10 propriation for the immediately succeeding fiscal  
11 year for grants under this section.

12           (4) PREVENTING DUPLICATION OF PAYMENT.—  
13 The payment under a MFP demonstration project  
14 with respect to qualified expenditures shall be in lieu  
15 of any payment with respect to such expenditures  
16 that could otherwise be paid under Medicaid, includ-  
17 ing under section 1903(a) of the Social Security Act.  
18 Nothing in the previous sentence shall be construed  
19 as preventing the payment under Medicaid for such  
20 expenditures in a grant year after amounts available  
21 to pay for such expenditures under the MFP dem-  
22 onstration project have been exhausted.

23           (5) MFP-ENHANCED FMAP.—For purposes of  
24 paragraph (1)(A), the “MFP-enhanced FMAP”, for  
25 a State for a fiscal year, is equal to the Federal

1 medical assistance percentage (as defined in the first  
2 sentence of section 1905(b)) for the State increased  
3 by a number of percentage points equal to 50 per-  
4 cent of the number of percentage points by which  
5 (A) such Federal medical assistance percentage for  
6 the State, is less than (B) 100 percent; but in no  
7 case shall the MFP-enhanced FMAP for a State ex-  
8 ceed 90 percent.

9 (f) QUALITY ASSURANCE AND IMPROVEMENT; TECH-  
10 NICAL ASSISTANCE; OVERSIGHT.—

11 (1) IN GENERAL.—The Secretary, either di-  
12 rectly or by grant or contract, shall provide for tech-  
13 nical assistance to, and oversight of, States for pur-  
14 poses of upgrading quality assurance and quality im-  
15 provement systems under Medicaid home and com-  
16 munity-based waivers, including—

17 (A) dissemination of information on prom-  
18 ising practices;

19 (B) guidance on system design elements  
20 addressing the unique needs of participating  
21 beneficiaries;

22 (C) ongoing consultation on quality, in-  
23 cluding assistance in developing necessary tools,  
24 resources, and monitoring systems; and

1 (D) guidance on remedying programmatic  
2 and systemic problems.

3 (2) FUNDING.—From the amounts appro-  
4 priated under subsection (h)(1) for the portion of  
5 fiscal year 2007 that begins on January 1, 2007,  
6 and ends on September 30, 2007, and for fiscal year  
7 2008, not more than \$2,400,000 shall be available  
8 to the Secretary to carry out this subsection during  
9 the period that begins on January 1, 2007, and ends  
10 on September 30, 2011.

11 (g) RESEARCH AND EVALUATION.—

12 (1) IN GENERAL.—The Secretary, directly or  
13 through grant or contract, shall provide for research  
14 on, and a national evaluation of, the program under  
15 this section, including assistance to the Secretary in  
16 preparing the final report required under paragraph  
17 (2). The evaluation shall include an analysis of pro-  
18 jected and actual savings related to the transition of  
19 individuals to qualified residences in each State con-  
20 ducting an MFP demonstration project.

21 (2) FINAL REPORT.—The Secretary shall make  
22 a final report to the President and Congress, not  
23 later than September 30, 2011, reflecting the eval-  
24 uation described in paragraph (1) and providing

1 findings and conclusions on the conduct and effec-  
2 tiveness of MFP demonstration projects.

3 (3) FUNDING.—From the amounts appro-  
4 priated under subsection (h)(1) for each of fiscal  
5 years 2008 through 2011, not more than \$1,100,000  
6 per year shall be available to the Secretary to carry  
7 out this subsection.

8 (h) APPROPRIATIONS.—

9 (1) IN GENERAL.—There are appropriated,  
10 from any funds in the Treasury not otherwise appro-  
11 priated, for grants to carry out this section—

12 (A) \$250,000,000 for the portion of fiscal  
13 year 2007 beginning on January 1, 2007, and  
14 ending on September 30, 2007;

15 (B) \$300,000,000 for fiscal year 2008;

16 (C) \$350,000,000 for fiscal year 2009;

17 (D) \$400,000,000 for fiscal year 2010;

18 and

19 (E) \$450,000,000 for fiscal year 2011.

20 (2) AVAILABILITY.—Amounts made available  
21 under paragraph (1) for a fiscal year shall remain  
22 available for the awarding of grants to States by not  
23 later than September 30, 2011.

1                   **Subchapter C—Miscellaneous**

2   **SEC. 6081. MEDICAID TRANSFORMATION GRANTS.**

3           (a) IN GENERAL.—Section 1903 of the Social Secu-  
4 rity Act (42 U.S.C. 1396b), as amended by sections  
5 6037(a)(2) and 6043(b), is amended by adding at the end  
6 the following new subsection:

7           “(z) MEDICAID TRANSFORMATION PAYMENTS.—

8                   “(1) IN GENERAL.—In addition to the pay-  
9 ments provided under subsection (a), subject to  
10 paragraph (4), the Secretary shall provide for pay-  
11 ments to States for the adoption of innovative meth-  
12 ods to improve the effectiveness and efficiency in  
13 providing medical assistance under this title.

14                   “(2) PERMISSIBLE USES OF FUNDS.—The fol-  
15 lowing are examples of innovative methods for which  
16 funds provided under this subsection may be used:

17                           “(A) Methods for reducing patient error  
18 rates through the implementation and use of  
19 electronic health records, electronic clinical deci-  
20 sion support tools, or e-prescribing programs.

21                           “(B) Methods for improving rates of collec-  
22 tion from estates of amounts owed under this  
23 title.

24                           “(C) Methods for reducing waste, fraud,  
25 and abuse under the program under this title,

1           such as reducing improper payment rates as  
2           measured by annual payment error rate meas-  
3           urement (PERM) project rates.

4           “(D) Implementation of a medication risk  
5           management program as part of a drug use re-  
6           view program under section 1927(g).

7           “(E) Methods in reducing, in clinically ap-  
8           propriate ways, expenditures under this title for  
9           covered outpatient drugs, particularly in the  
10          categories of greatest drug utilization, by in-  
11          creasing the utilization of generic drugs  
12          through the use of education programs and  
13          other incentives to promote greater use of ge-  
14          neric drugs.

15          “(F) Methods for improving access to pri-  
16          mary and specialty physician care for the unin-  
17          sured using integrated university-based hospital  
18          and clinic systems.

19          “(3) APPLICATION; TERMS AND CONDITIONS.—

20                 “(A) IN GENERAL.—No payments shall be  
21                 made to a State under this subsection unless  
22                 the State applies to the Secretary for such pay-  
23                 ments in a form, manner, and time specified by  
24                 the Secretary.

1           “(B) TERMS AND CONDITIONS.—Such pay-  
2           ments are made under such terms and condi-  
3           tions consistent with this subsection as the Sec-  
4           retary prescribes.

5           “(C) ANNUAL REPORT.—Payment to a  
6           State under this subsection is conditioned on  
7           the State submitting to the Secretary an annual  
8           report on the programs supported by such pay-  
9           ment. Such report shall include information  
10          on—

11                   “(i) the specific uses of such payment;

12                   “(ii) an assessment of quality im-  
13                   provements and clinical outcomes under  
14                   such programs; and

15                   “(iii) estimates of cost savings result-  
16                   ing from such programs.

17          “(4) FUNDING.—

18           “(A) LIMITATION ON FUNDS.—The total  
19           amount of payments under this subsection shall  
20           be equal to, and shall not exceed—

21                   “(i) \$75,000,000 for fiscal year 2007;

22                   and

23                   “(ii) \$75,000,000 for fiscal year 2008.

24          This subsection constitutes budget authority in  
25          advance of appropriations Acts and represents

1 the obligation of the Secretary to provide for  
2 the payment of amounts provided under this  
3 subsection.

4 “(B) ALLOCATION OF FUNDS.—The Sec-  
5 retary shall specify a method for allocating the  
6 funds made available under this subsection  
7 among States. Such method shall provide pref-  
8 erence for States that design programs that  
9 target health providers that treat significant  
10 numbers of Medicaid beneficiaries. Such method  
11 shall provide that not less than 25 percent of  
12 such funds shall be allocated among States the  
13 population of which (as determined according to  
14 data collected by the United States Census Bu-  
15 reau) as of July 1, 2004, was more than 105  
16 percent of the population of the respective State  
17 (as so determined) as of April 1, 2000.

18 “(C) FORM AND MANNER OF PAYMENT.—  
19 Payment to a State under this subsection shall  
20 be made in the same manner as other payments  
21 under section 1903(a). There is no requirement  
22 for State matching funds to receive payments  
23 under this subsection.

24 “(5) MEDICATION RISK MANAGEMENT PRO-  
25 GRAM.—



1           “(A) IN GENERAL.—For purposes of this  
2 subsection, the term ‘medication risk manage-  
3 ment program’ means a program for targeted  
4 beneficiaries that ensures that covered out-  
5 patient drugs are appropriately used to opti-  
6 mize therapeutic outcomes through improved  
7 medication use and to reduce the risk of ad-  
8 verse events.

9           “(B) ELEMENTS.—Such program may in-  
10 clude the following elements:

11           “(i) The use of established principles  
12 and standards for drug utilization review  
13 and best practices to analyze prescription  
14 drug claims of targeted beneficiaries and  
15 identify outlier physicians.

16           “(ii) On an ongoing basis provide  
17 outlier physicians—

18           “(I) a comprehensive pharmacy  
19 claims history for each targeted bene-  
20 ficiary under their care;

21           “(II) information regarding the  
22 frequency and cost of relapses and  
23 hospitalizations of targeted bene-  
24 ficiaries under the physician’s care;  
25 and

1                   “(III) applicable best practice  
2                   guidelines and empirical references.

3                   “(iii) Monitor outlier physician’s pre-  
4                   scribing, such as failure to refill, dosage  
5                   strengths, and provide incentives and in-  
6                   formation to encourage the adoption of  
7                   best clinical practices.

8                   “(C) TARGETED BENEFICIARIES.—For  
9                   purposes of this paragraph, the term ‘targeted  
10                  beneficiaries’ means Medicaid eligible bene-  
11                  ficiaries who are identified as having high pre-  
12                  scription drug costs and medical costs, such as  
13                  individuals with behavioral disorders or multiple  
14                  chronic diseases who are taking multiple medi-  
15                  cations.”.

16 **SEC. 6082. HEALTH OPPORTUNITY ACCOUNTS.**

17           Title XIX of the Social Security Act, as amended by  
18   sections 6035 and 6044, is amended—

19           (1) by redesignating section 1938 as section  
20           1939; and

21           (2) by inserting after section 1937 the following  
22   new section:

23           “HEALTH OPPORTUNITY ACCOUNTS

24           “SEC. 1938. (a) AUTHORITY.—

25           “(1) IN GENERAL.—Notwithstanding any other  
26   provision of this title, the Secretary shall establish a

1 demonstration program under which States may pro-  
2 vide under their State plans under this title (includ-  
3 ing such a plan operating under a statewide waiver  
4 under section 1115) in accordance with this section  
5 for the provision of alternative benefits consistent  
6 with subsection (c) for eligible population groups in  
7 one or more geographic areas of the State specified  
8 by the State. An amendment under the previous sen-  
9 tence is referred to in this section as a ‘State dem-  
10 onstration program’.

11 “(2) INITIAL DEMONSTRATION.—

12 “(A) IN GENERAL.—The demonstration  
13 program under this section shall begin on Janu-  
14 ary 1, 2007. During the first 5 years of such  
15 program, the Secretary shall not approve more  
16 than 10 States to conduct demonstration pro-  
17 grams under this section, with each State dem-  
18 onstration program covering 1 or more geo-  
19 graphic areas specified by the State. After such  
20 5-year period—

21 “(i) unless the Secretary finds, taking  
22 into account cost-effectiveness, quality of  
23 care, and other criteria that the Secretary  
24 specifies, that a State demonstration pro-  
25 gram previously implemented has been un-

1           successful, such a demonstration program  
2           may be extended or made permanent in  
3           the State; and

4                   “(ii) unless the Secretary finds, taking  
5           into account cost-effectiveness, quality of  
6           care, and other criteria that the Secretary  
7           specifies, that all State demonstration pro-  
8           grams previously implemented were unsuc-  
9           cessful, other States may implement State  
10          demonstration programs.

11         “(B) GAO REPORT.—

12                   “(i) IN GENERAL.—Not later than 3  
13          months after the end of the 5-year period  
14          described in subparagraph (A), the Comp-  
15          troller General of the United States shall  
16          submit a report to Congress evaluating the  
17          demonstration programs conducted under  
18          this section during such period.

19                   “(ii) APPROPRIATION.—Out of any  
20          funds in the Treasury not otherwise appro-  
21          priated, there is appropriated to the Comp-  
22          troller General of the United States,  
23          \$550,000 for the period of fiscal years  
24          2007 through 2010 to carry out clause (i).

1           “(3) APPROVAL.—The Secretary shall not ap-  
2           prove a State demonstration program under para-  
3           graph (1) unless the program includes the following:

4                   “(A) Creating patient awareness of the  
5                   high cost of medical care.

6                   “(B) Providing incentives to patients to  
7                   seek preventive care services.

8                   “(C) Reducing inappropriate use of health  
9                   care services.

10                  “(D) Enabling patients to take responsi-  
11                  bility for health outcomes.

12                  “(E) Providing enrollment counselors and  
13                  ongoing education activities.

14                  “(F) Providing transactions involving  
15                  health opportunity accounts to be conducted  
16                  electronically and without cash.

17                  “(G) Providing access to negotiated pro-  
18                  vider payment rates consistent with this section.

19           Nothing in this section shall be construed as pre-  
20           venting a State demonstration program from pro-  
21           viding incentives for patients obtaining appropriate  
22           preventive care (as defined for purposes of section  
23           223(c)(2)(C) of the Internal Revenue Code of 1986),  
24           such as additional account contributions for an indi-  
25           vidual demonstrating healthy prevention practices.

1           “(4)           No           REQUIREMENT           FOR  
2           STATEWIDENESS.—Nothing in this section or any  
3           other provision of law shall be construed to require  
4           that a State must provide for the implementation of  
5           a State demonstration program on a Statewide  
6           basis.

7           “(b) ELIGIBLE POPULATION GROUPS.—

8                 “(1) IN GENERAL.—A State demonstration pro-  
9           gram under this section shall specify the eligible  
10          population groups consistent with paragraphs (2)  
11          and (3).

12                “(2) ELIGIBILITY LIMITATIONS DURING INITIAL  
13          DEMONSTRATION PERIOD.—During the initial 5  
14          years of the demonstration program under this sec-  
15          tion, a State demonstration program shall not apply  
16          to any of the following individuals:

17                   “(A) Individuals who are 65 years of age  
18                  or older.

19                   “(B) Individuals who are disabled, regard-  
20          less of whether or not their eligibility for med-  
21          ical assistance under this title is based on such  
22          disability.

23                   “(C) Individuals who are eligible for med-  
24          ical assistance under this title only because they

1           are (or were within the previous 60 days) preg-  
2           nant.

3           “(D) Individuals who have been eligible for  
4           medical assistance for a continuous period of  
5           less than 3 months.

6           “(3) ADDITIONAL LIMITATIONS.—A State dem-  
7           onstration program shall not apply to any individual  
8           within a category of individuals described in section  
9           1937(a)(2)(B).

10          “(4) LIMITATIONS.—

11           “(A) STATE OPTION.—This subsection  
12           shall not be construed as preventing a State  
13           from further limiting eligibility.

14           “(B) ON ENROLLEES IN MEDICAID MAN-  
15           AGED CARE ORGANIZATIONS.—Insofar as the  
16           State provides for eligibility of individuals who  
17           are enrolled in medicaid managed care organi-  
18           zations, such individuals may participate in the  
19           State demonstration program only if the State  
20           provides assurances satisfactory to the Sec-  
21           retary that the following conditions are met  
22           with respect to any such organization:

23           “(i) In no case may the number of  
24           such individuals enrolled in the organiza-  
25           tion who participate in the program exceed

1                   5 percent of the total number of individ-  
2                   uals enrolled in such organization.

3                   “(ii) The proportion of enrollees in  
4                   the organization who so participate is not  
5                   significantly disproportionate to the pro-  
6                   portion of such enrollees in other such or-  
7                   ganizations who participate.

8                   “(iii) The State has provided for an  
9                   appropriate adjustment in the per capita  
10                  payments to the organization to account  
11                  for such participation, taking into account  
12                  differences in the likely use of health serv-  
13                  ices between enrollees who so participate  
14                  and enrollees who do not so participate.

15                  “(5) VOLUNTARY PARTICIPATION.—An eligible  
16                  individual shall be enrolled in a State demonstration  
17                  program only if the individual voluntarily enrolls.  
18                  Except in such hardship cases as the Secretary shall  
19                  specify, such an enrollment shall be effective for a  
20                  period of 12 months, but may be extended for addi-  
21                  tional periods of 12 months each with the consent of  
22                  the individual.

23                  “(6) 1-YEAR MORATORIUM FOR REENROLL-  
24                  MENT.—An eligible individual who, for any reason,  
25                  is disenrolled from a State demonstration program



1       conducted under this section shall not be permitted  
2       to reenroll in such program before the end of the 1-  
3       year period that begins on the effective date of such  
4       disenrollment.

5       “(c) ALTERNATIVE BENEFITS.—

6               “(1) IN GENERAL.—The alternative benefits  
7       provided under this section shall consist, consistent  
8       with this subsection, of at least—

9               “(A) coverage for medical expenses in a  
10       year for items and services for which benefits  
11       are otherwise provided under this title after an  
12       annual deductible described in paragraph (2)  
13       has been met; and

14              “(B) contribution into a health opportunity  
15       account.

16       Nothing in subparagraph (A) shall be construed as  
17       preventing a State from providing for coverage of  
18       preventive care (referred to in subsection (a)(3))  
19       within the alternative benefits without regard to the  
20       annual deductible.

21              “(2) ANNUAL DEDUCTIBLE.—The amount of  
22       the annual deductible described in paragraph (1)(A)  
23       shall be at least 100 percent, but no more than 110  
24       percent, of the annualized amount of contributions  
25       to the health opportunity account under subsection

1 (d)(2)(A)(i), determined without regard to any limi-  
2 tation described in subsection (d)(2)(C)(i)(II).

3 “(3) ACCESS TO NEGOTIATED PROVIDER PAY-  
4 MENT RATES.—

5 “(A) FEE-FOR-SERVICE ENROLLEES.—In  
6 the case of an individual who is participating in  
7 a State demonstration program and who is not  
8 enrolled with a medicaid managed care organi-  
9 zation, the State shall provide that the indi-  
10 vidual may obtain demonstration program med-  
11 icaid services from—

12 “(i) any participating provider under  
13 this title at the same payment rates that  
14 would be applicable to such services if the  
15 deductible described in paragraph (1)(A)  
16 was not applicable; or

17 “(ii) any other provider at payment  
18 rates that do not exceed 125 percent of the  
19 payment rate that would be applicable to  
20 such services furnished by a participating  
21 provider under this title if the deductible  
22 described in paragraph (1)(A) was not ap-  
23 plicable.

24 “(B) TREATMENT UNDER MEDICAID MAN-  
25 AGED CARE PLANS.—In the case of an indi-

1           vidual who is participating in a State dem-  
2           onstration program and is enrolled with a med-  
3           icaid managed care organization, the State shall  
4           enter into an arrangement with the organiza-  
5           tion under which the individual may obtain  
6           demonstration program medicaid services from  
7           any provider described in clause (ii) of subpara-  
8           graph (A) at payment rates that do not exceed  
9           the payment rates that may be imposed under  
10          that clause.

11               “(C) COMPUTATION.—The payment rates  
12           described in subparagraphs (A) and (B) shall  
13           be computed without regard to any cost sharing  
14           that would be otherwise applicable under sec-  
15           tions 1916 and 1916A.

16               “(D) DEFINITIONS.—For purposes of this  
17           paragraph:

18                   “(i) The term ‘demonstration program  
19           medicaid services’ means, with respect to  
20           an individual participating in a State dem-  
21           onstration program, services for which the  
22           individual would be provided medical as-  
23           sistance under this title but for the appli-  
24           cation of the deductible described in para-  
25           graph (1)(A).

1 “(ii) The term ‘participating provider’  
2 means—

3 “(I) with respect to an individual  
4 described in subparagraph (A), a  
5 health care provider that has entered  
6 into a participation agreement with  
7 the State for the provision of services  
8 to individuals entitled to benefits  
9 under the State plan; or

10 “(II) with respect to an indi-  
11 vidual described in subparagraph (B)  
12 who is enrolled in a medicaid man-  
13 aged care organization, a health care  
14 provider that has entered into an ar-  
15 rangement for the provision of serv-  
16 ices to enrollees of the organization  
17 under this title.

18 “(4) NO EFFECT ON SUBSEQUENT BENEFITS.—  
19 Except as provided under paragraphs (1) and (2),  
20 alternative benefits for an eligible individual shall  
21 consist of the benefits otherwise provided to the indi-  
22 vidual, including cost sharing relating to such bene-  
23 fits.

24 “(5) OVERRIDING COST SHARING AND COM-  
25 PARABILITY REQUIREMENTS FOR ALTERNATIVE

1 BENEFITS.—The provisions of this title relating to  
2 cost sharing for benefits (including sections 1916  
3 and 1916A) shall not apply with respect to benefits  
4 to which the annual deductible under paragraph  
5 (1)(A) applies. The provisions of section  
6 1902(a)(10)(B) (relating to comparability) shall not  
7 apply with respect to the provision of alternative  
8 benefits (as described in this subsection).

9 “(6) TREATMENT AS MEDICAL ASSISTANCE.—  
10 Subject to subparagraphs (D) and (E) of subsection  
11 (d)(2), payments for alternative benefits under this  
12 section (including contributions into a health oppor-  
13 tunity account) shall be treated as medical assist-  
14 ance for purposes of section 1903(a).

15 “(7) USE OF TIERED DEDUCTIBLE AND COST  
16 SHARING.—

17 “(A) IN GENERAL.—A State—

18 “(i) may vary the amount of the an-  
19 nual deductible applied under paragraph  
20 (1)(A) based on the income of the family  
21 involved so long as it does not favor fami-  
22 lies with higher income over those with  
23 lower income; and

24 “(ii) may vary the amount of the max-  
25 imum out-of-pocket cost sharing (as de-

1           fined in subparagraph (B)) based on the  
2           income of the family involved so long as it  
3           does not favor families with higher income  
4           over those with lower income.

5           “(B) MAXIMUM OUT-OF-POCKET COST  
6           SHARING.—For purposes of subparagraph  
7           (A)(ii), the term ‘maximum out-of-pocket cost  
8           sharing’ means, for an individual or family, the  
9           amount by which the annual deductible level ap-  
10          plied under paragraph (1)(A) to the individual  
11          or family exceeds the balance in the health op-  
12          portunity account for the individual or family.

13          “(8) CONTRIBUTIONS BY EMPLOYERS.—Noth-  
14          ing in this section shall be construed as preventing  
15          an employer from providing health benefits coverage  
16          consisting of the coverage described in paragraph  
17          (1)(A) to individuals who are provided alternative  
18          benefits under this section.

19          “(d) HEALTH OPPORTUNITY ACCOUNT.—

20                 “(1) IN GENERAL.—For purposes of this sec-  
21          tion, the term ‘health opportunity account’ means an  
22          account that meets the requirements of this sub-  
23          section.

24                 “(2) CONTRIBUTIONS.—

1           “(A) IN GENERAL.—No contribution may  
2           be made into a health opportunity account  
3           except—

4                   “(i) contributions by the State under  
5                   this title; and

6                   “(ii) contributions by other persons  
7                   and entities, such as charitable organiza-  
8                   tions, as permitted under section 1903(w).

9           “(B) STATE CONTRIBUTION.—A State  
10          shall specify the contribution amount that shall  
11          be deposited under subparagraph (A)(i) into a  
12          health opportunity account.

13          “(C) LIMITATION ON ANNUAL STATE CON-  
14          TRIBUTION PROVIDED AND PERMITTING IMPO-  
15          SITION OF MAXIMUM ACCOUNT BALANCE.—

16                   “(i) IN GENERAL.—A State—

17                           “(I) may impose limitations on  
18                           the maximum contributions that may  
19                           be deposited under subparagraph  
20                           (A)(i) into a health opportunity ac-  
21                           count in a year;

22                           “(II) may limit contributions into  
23                           such an account once the balance in  
24                           the account reaches a level specified  
25                           by the State; and

1                   “(III) subject to clauses (ii) and  
2                   (iii) and subparagraph (D)(i), may  
3                   not provide contributions described in  
4                   subparagraph (A)(i) to a health op-  
5                   portunity account on behalf of an in-  
6                   dividual or family to the extent the  
7                   amount of such contributions (includ-  
8                   ing both State and Federal shares)  
9                   exceeds, on an annual basis, \$2,500  
10                  for each individual (or family mem-  
11                  ber) who is an adult and \$1,000 for  
12                  each individual (or family member)  
13                  who is a child.

14                  “(ii) INDEXING OF DOLLAR LIMITA-  
15                  TIONS.—For each year after 2006, the dol-  
16                  lar amounts specified in clause (i)(III)  
17                  shall be annually increased by the Sec-  
18                  retary by a percentage that reflects the an-  
19                  nual percentage increase in the medical  
20                  care component of the consumer price  
21                  index for all urban consumers.

22                  “(iii) BUDGET NEUTRAL ADJUST-  
23                  MENT.—A State may provide for dollar  
24                  limitations in excess of those specified in  
25                  clause (i)(III) (as increased under clause



1 (ii) for specified individuals if the State  
2 provides assurances satisfactory to the Sec-  
3 retary that contributions otherwise made  
4 to other individuals will be reduced in a  
5 manner so as to provide for aggregate con-  
6 tributions that do not exceed the aggregate  
7 contributions that would otherwise be per-  
8 mitted under this subparagraph.

9 “(D) LIMITATIONS ON FEDERAL MATCH-  
10 ING.—

11 “(i) STATE CONTRIBUTION.—A State  
12 may contribute under subparagraph (A)(i)  
13 amounts to a health opportunity account in  
14 excess of the limitations provided under  
15 subparagraph (C)(i)(III), but no Federal  
16 financial participation shall be provided  
17 under section 1903(a) with respect to con-  
18 tributions in excess of such limitations.

19 “(ii) NO FFP FOR PRIVATE CONTRIBU-  
20 TIONS.—No Federal financial participation  
21 shall be provided under section 1903(a)  
22 with respect to any contributions described  
23 in subparagraph (A)(ii) to a health oppor-  
24 tunity account.

1           “(E) APPLICATION OF DIFFERENT MATCH-  
2           ING RATES.—The Secretary shall provide a  
3           method under which, for expenditures made  
4           from a health opportunity account for medical  
5           care for which the Federal matching rate under  
6           section 1903(a) exceeds the Federal medical as-  
7           sistance percentage, a State may obtain pay-  
8           ment under such section at such higher match-  
9           ing rate for such expenditures.

10          “(3) USE.—

11           “(A) GENERAL USES.—

12           “(i) IN GENERAL.—Subject to the  
13           succeeding provisions of this paragraph,  
14           amounts in a health opportunity account  
15           may be used for payment of such health  
16           care expenditures as the State specifies.

17           “(ii) GENERAL LIMITATION.—Subject  
18           to subparagraph (B)(ii), in no case shall  
19           such account be used for payment for  
20           health care expenditures that are not pay-  
21           ment of medical care (as defined by section  
22           213(d) of the Internal Revenue Code of  
23           1986).

1           “(iii) STATE RESTRICTIONS.—In ap-  
2           plying clause (i), a State may restrict pay-  
3           ment for—

4                   “(I) providers of items and serv-  
5                   ices to providers that are licensed or  
6                   otherwise authorized under State law  
7                   to provide the item or service and may  
8                   deny payment for such a provider on  
9                   the basis that the provider has been  
10                  found, whether with respect to this  
11                  title or any other health benefit pro-  
12                  gram, to have failed to meet quality  
13                  standards or to have committed 1 or  
14                  more acts of fraud or abuse; and

15                  “(II) items and services insofar  
16                  as the State finds they are not medi-  
17                  cally appropriate or necessary.

18           “(iv) ELECTRONIC WITHDRAWALS.—  
19           The State demonstration program shall  
20           provide for a method whereby withdrawals  
21           may be made from the account for such  
22           purposes using an electronic system and  
23           shall not permit withdrawals from the ac-  
24           count in cash.

1                   “(B) MAINTENANCE OF HEALTH OPPOR-  
2                   TUNITY ACCOUNT AFTER BECOMING INELI-  
3                   GIBLE FOR PUBLIC BENEFIT.—

4                   “(i) IN GENERAL.—Notwithstanding  
5                   any other provision of law, if an account  
6                   holder of a health opportunity account be-  
7                   comes ineligible for benefits under this title  
8                   because of an increase in income or  
9                   assets—

10                   “(I) no additional contribution  
11                   shall be made into the account under  
12                   paragraph (2)(A)(i);

13                   “(II) subject to clause (iii), the  
14                   balance in the account shall be re-  
15                   duced by 25 percent; and

16                   “(III) subject to the succeeding  
17                   provisions of this subparagraph, the  
18                   account shall remain available to the  
19                   account holder for 3 years after the  
20                   date on which the individual becomes  
21                   ineligible for such benefits for with-  
22                   drawals under the same terms and  
23                   conditions as if the account holder re-  
24                   mained eligible for such benefits, and  
25                   such withdrawals shall be treated as

1 medical assistance in accordance with  
2 subsection (c)(6).

3 “(ii) SPECIAL RULES.—Withdrawals  
4 under this subparagraph from an  
5 account—

6 “(I) shall be available for the  
7 purchase of health insurance coverage;  
8 and

9 “(II) may, subject to clause (iv),  
10 be made available (at the option of  
11 the State) for such additional expendi-  
12 tures (such as job training and tuition  
13 expenses) specified by the State (and  
14 approved by the Secretary) as the  
15 State may specify.

16 “(iii) EXCEPTION FROM 25 PERCENT  
17 SAVINGS TO GOVERNMENT FOR PRIVATE  
18 CONTRIBUTIONS.—Clause (i)(II) shall not  
19 apply to the portion of the account that is  
20 attributable to contributions described in  
21 paragraph (2)(A)(ii). For purposes of ac-  
22 counting for such contributions, with-  
23 draws from a health opportunity account  
24 shall first be attributed to contributions  
25 described in paragraph (2)(A)(i).

1                   “(iv) CONDITION FOR NON-HEALTH  
2                   WITHDRAWALS.—No withdrawal may be  
3                   made from an account under clause (ii)(II)  
4                   unless the accountholder has participated  
5                   in the program under this section for at  
6                   least 1 year.

7                   “(v) NO REQUIREMENT FOR CONTINU-  
8                   ATION OF COVERAGE.—An account holder  
9                   of a health opportunity account, after be-  
10                  coming ineligible for medical assistance  
11                  under this title, is not required to purchase  
12                  high-deductible or other insurance as a  
13                  condition of maintaining or using the ac-  
14                  count.

15               “(4) ADMINISTRATION.—A State may coordi-  
16               nate administration of health opportunity accounts  
17               through the use of a third party administrator and  
18               reasonable expenditures for the use of such adminis-  
19               trator shall be reimbursable to the State in the same  
20               manner as other administrative expenditures under  
21               section 1903(a)(7).

22               “(5) TREATMENT.—Amounts in, or contributed  
23               to, a health opportunity account shall not be counted  
24               as income or assets for purposes of determining eli-  
25               gibility for benefits under this title.

1           “(6) UNAUTHORIZED WITHDRAWALS.—A State  
2           may establish procedures—

3                   “(A) to penalize or remove an individual  
4                   from the health opportunity account based on  
5                   nonqualified withdrawals by the individual from  
6                   such an account; and

7                   “(B) to recoup costs that derive from such  
8                   nonqualified withdrawals.”.

9   **SEC. 6083. STATE OPTION TO ESTABLISH NON-EMERGENCY**  
10                   **MEDICAL TRANSPORTATION PROGRAM.**

11           (a) IN GENERAL.—Section 1902(a) of the Social Se-  
12           curity Act (42 U.S.C. 1396a(a)), as amended by sections  
13           6033(a) and 6035(b), is amended—

14                   (1) in paragraph (68), by striking “and” at the  
15                   end;

16                   (2) in paragraph (69) by striking the period at  
17                   the end and inserting “; and”; and

18                   (3) by inserting after paragraph (69) the fol-  
19                   lowing:

20                   “(70) at the option of the State and notwith-  
21                   standing paragraphs (1), (10)(B), and (23), provide  
22                   for the establishment of a non-emergency medical  
23                   transportation brokerage program in order to more  
24                   cost-effectively provide transportation for individuals  
25                   eligible for medical assistance under the State plan

1       who need access to medical care or services and have  
2       no other means of transportation which—

3               “(A) may include a wheelchair van, taxi,  
4       stretcher car, bus passes and tickets, secured  
5       transportation, and such other transportation  
6       as the Secretary determines appropriate; and

7               “(B) may be conducted under contract  
8       with a broker who—

9               “(i) is selected through a competitive  
10       bidding process based on the State’s eval-  
11       uation of the broker’s experience, perform-  
12       ance, references, resources, qualifications,  
13       and costs;

14              “(ii) has oversight procedures to mon-  
15       itor beneficiary access and complaints and  
16       ensure that transport personnel are li-  
17       censed, qualified, competent, and cour-  
18       teous;

19              “(iii) is subject to regular auditing  
20       and oversight by the State in order to en-  
21       sure the quality of the transportation serv-  
22       ices provided and the adequacy of bene-  
23       ficiary access to medical care and services;  
24       and



1                   “(iv) complies with such requirements  
2                   related to prohibitions on referrals and  
3                   conflict of interest as the Secretary shall  
4                   establish (based on the prohibitions on  
5                   physician referrals under section 1877 and  
6                   such other prohibitions and requirements  
7                   as the Secretary determines to be appro-  
8                   priate).”.

9           (b) EFFECTIVE DATE.—The amendments made by  
10 subsection (a) take effect on the date of the enactment  
11 of this Act.

12 **SEC. 6084. EXTENSION OF TRANSITIONAL MEDICAL ASSIST-**  
13 **ANCE (TMA) AND ABSTINENCE EDUCATION**  
14 **PROGRAM.**

15           Effective as if enacted on December 31, 2005, activi-  
16 ties authorized by sections 510 and 1925 of the Social Se-  
17 curity Act shall continue through December 31, 2006, in  
18 the manner authorized for fiscal year 2005, notwith-  
19 standing section 1902(e)(1)(A) of such Act, and out of  
20 any money in the Treasury of the United States not other-  
21 wise appropriated, there are hereby appropriated such  
22 sums as may be necessary for such purpose. Grants and  
23 payments may be made pursuant to this authority through  
24 the first quarter of fiscal year 2007 at the level provided

1 for such activities through the first quarter of fiscal year  
2 2006.

3 **SEC. 6085. EMERGENCY SERVICES FURNISHED BY NON-**  
4 **CONTRACT PROVIDERS FOR MEDICAID MAN-**  
5 **AGED CARE ENROLLEES.**

6 (a) IN GENERAL.—Section 1932(b)(2) of the Social  
7 Security Act (42 U.S.C. 1396u–2(b)(2)) is amended by  
8 adding at the end the following new subparagraph:

9 “(D) EMERGENCY SERVICES FURNISHED  
10 BY NON-CONTRACT PROVIDERS.—Any provider  
11 of emergency services that does not have in ef-  
12 fect a contract with a medicaid managed care  
13 entity that establishes payment amounts for  
14 services furnished to a beneficiary enrolled in  
15 the entity’s Medicaid managed care plan must  
16 accept as payment in full no more than the  
17 amounts (less any payments for indirect costs  
18 of medical education and direct costs of grad-  
19 uate medical education) that it could collect if  
20 the beneficiary received medical assistance  
21 under this title other than through enrollment  
22 in such an entity. In a State where rates paid  
23 to hospitals under the State plan are negotiated  
24 by contract and not publicly released, the pay-  
25 ment amount applicable under this subpara-

1 graph shall be the average contract rate that  
2 would apply under the State plan for general  
3 acute care hospitals or the average contract  
4 rate that would apply under such plan for ter-  
5 tiary hospitals.”.

6 (b) EFFECTIVE DATE.—The amendment made by  
7 subsection (a) shall take effect on January 1, 2007.

8 **SEC. 6086. EXPANDED ACCESS TO HOME AND COMMUNITY-**  
9 **BASED SERVICES FOR THE ELDERLY AND**  
10 **DISABLED.**

11 (a) HOME AND COMMUNITY-BASED SERVICES AS AN  
12 OPTIONAL BENEFIT FOR ELDERLY AND DISABLED INDIVIDUALS.—Section 1915 of the Social Security Act (42  
13 U.S.C. 1396n) is amended by adding at the end the fol-  
14 lowing new subsection:  
15

16 “(i) STATE PLAN AMENDMENT OPTION TO PROVIDE  
17 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY  
18 AND DISABLED INDIVIDUALS.—

19 “(1) IN GENERAL.—Subject to the succeeding  
20 provisions of this subsection, a State may provide  
21 through a State plan amendment for the provision  
22 of medical assistance for home and community-based  
23 services (within the scope of services described in  
24 paragraph (4)(B) of subsection (c) for which the  
25 Secretary has the authority to approve a waiver and

1 not including room and board or such other services  
2 requested by the State as the Secretary may ap-  
3 prove) for individuals eligible for medical assistance  
4 under the State plan whose income does not exceed  
5 150 percent of the poverty line (as defined in section  
6 2110(c)(5)), without determining that but for the  
7 provision of such services the individuals would re-  
8 quire the level of care provided in a hospital or a  
9 nursing facility or intermediate care facility for the  
10 mentally retarded, but only if the State meets the  
11 following requirements:

12 “(A) NEEDS-BASED CRITERIA FOR ELIGI-  
13 BILITY FOR, AND RECEIPT OF, HOME AND COM-  
14 MUNITY-BASED SERVICES.—The State estab-  
15 lishes needs-based criteria for determining an  
16 individual’s eligibility under the State plan for  
17 medical assistance for such home and commu-  
18 nity-based services, and if the individual is eligi-  
19 ble for such services, the specific home and  
20 community-based services that the individual  
21 will receive.

22 “(B) ESTABLISHMENT OF MORE STRIN-  
23 GENT NEEDS-BASED ELIGIBILITY CRITERIA FOR  
24 INSTITUTIONALIZED CARE.—The State estab-  
25 lishes needs-based criteria for determining

1           whether an individual requires the level of care  
2           provided in a hospital, a nursing facility, or an  
3           intermediate care facility for the mentally re-  
4           tarded under the State plan or under any waiv-  
5           er of such plan that are more stringent than  
6           the needs-based criteria established under sub-  
7           paragraph (A) for determining eligibility for  
8           home and community-based services.

9                   “(C) PROJECTION OF NUMBER OF INDI-  
10           VIDUALS TO BE PROVIDED HOME AND COMMU-  
11           NITY-BASED SERVICES.—

12                   “(i) IN GENERAL.—The State submits  
13           to the Secretary, in such form and man-  
14           ner, and upon such frequency as the Sec-  
15           retary shall specify, the projected number  
16           of individuals to be provided home and  
17           community-based services.

18                   “(ii) AUTHORITY TO LIMIT NUMBER  
19           OF ELIGIBLE INDIVIDUALS.—A State may  
20           limit the number of individuals who are eli-  
21           gible for such services and may establish  
22           waiting lists for the receipt of such serv-  
23           ices.

24                   “(D) CRITERIA BASED ON INDIVIDUAL AS-  
25           SESSMENT.—



1 the public of the proposed modifica-  
2 tion;

3 “(II) the State deems an indi-  
4 vidual receiving home and community-  
5 based services on the basis of the  
6 most recent version of the criteria in  
7 effect prior to the effective date of the  
8 modification to be eligible for such  
9 services for a period of at least 12  
10 months beginning on the date the in-  
11 dividual first received medical assist-  
12 ance for such services; and

13 “(III) after the effective date of  
14 such modification, the State, at a  
15 minimum, applies the criteria for de-  
16 termining whether an individual re-  
17 quires the level of care provided in a  
18 hospital, a nursing facility, or an in-  
19 termediate care facility for the men-  
20 tally retarded under the State plan or  
21 under any waiver of such plan which  
22 applied prior to the application of the  
23 more stringent criteria developed  
24 under subparagraph (B).

1                   “(E) INDEPENDENT EVALUATION AND AS-  
2                   SESSMENT.—

3                   “(i) ELIGIBILITY DETERMINATION.—

4                   The State uses an independent evaluation  
5                   for making the determinations described in  
6                   subparagraphs (A) and (B).

7                   “(ii) ASSESSMENT.—In the case of an  
8                   individual who is determined to be eligible  
9                   for home and community-based services,  
10                  the State uses an independent assessment,  
11                  based on the needs of the individual to—

12                  “(I) determine a necessary level  
13                  of services and supports to be pro-  
14                  vided, consistent with an individual’s  
15                  physical and mental capacity;

16                  “(II) prevent the provision of un-  
17                  necessary or inappropriate care; and

18                  “(III) establish an individualized  
19                  care plan for the individual in accord-  
20                  ance with subparagraph (G).

21                  “(F) ASSESSMENT.—The independent as-  
22                  sessment required under subparagraph (E)(ii)  
23                  shall include the following:

24                  “(i) An objective evaluation of an in-  
25                  dividual’s inability to perform 2 or more



1 activities of daily living (as defined in sec-  
2 tion 7702B(c)(2)(B) of the Internal Rev-  
3 enue Code of 1986) or the need for signifi-  
4 cant assistance to perform such activities.

5 “(ii) A face-to-face evaluation of the  
6 individual by an individual trained in the  
7 assessment and evaluation of individuals  
8 whose physical or mental conditions trigger  
9 a potential need for home and community-  
10 based services.

11 “(iii) Where appropriate, consultation  
12 with the individual’s family, spouse, guard-  
13 ian, or other responsible individual.

14 “(iv) Consultation with appropriate  
15 treating and consulting health and support  
16 professionals caring for the individual.

17 “(v) An examination of the individ-  
18 ual’s relevant history, medical records, and  
19 care and support needs, guided by best  
20 practices and research on effective strate-  
21 gies that result in improved health and  
22 quality of life outcomes.

23 “(vi) If the State offers individuals  
24 the option to self-direct the purchase of, or  
25 control the receipt of, home and commu-

1 nity-based service, an evaluation of the  
2 ability of the individual or the individual's  
3 representative to self-direct the purchase  
4 of, or control the receipt of, such services  
5 if the individual so elects.

6 “(G) INDIVIDUALIZED CARE PLAN.—

7 “(i) IN GENERAL.—In the case of an  
8 individual who is determined to be eligible  
9 for home and community-based services,  
10 the State uses the independent assessment  
11 required under subparagraph (E)(ii) to es-  
12 tablish a written individualized care plan  
13 for the individual.

14 “(ii) PLAN REQUIREMENTS.—The  
15 State ensures that the individualized care  
16 plan for an individual—

17 “(I) is developed—

18 “(aa) in consultation with  
19 the individual, the individual's  
20 treating physician, health care or  
21 support professional, or other ap-  
22 propriate individuals, as defined  
23 by the State, and, where appro-  
24 priate the individual's family,  
25 caregiver, or representative; and

1                   “(bb) taking into account  
2                   the extent of, and need for, any  
3                   family or other supports for the  
4                   individual;

5                   “(II) identifies the necessary  
6                   home and community-based services  
7                   to be furnished to the individual (or,  
8                   if the individual elects to self-direct  
9                   the purchase of, or control the receipt  
10                  of, such services, funded for the indi-  
11                  vidual); and

12                  “(III) is reviewed at least annu-  
13                  ally and as needed when there is a  
14                  significant change in the individual’s  
15                  circumstances.

16                  “(iii) STATE OPTION TO OFFER ELEC-  
17                  TION FOR SELF-DIRECTED SERVICES.—

18                  “(I) INDIVIDUAL CHOICE.—At  
19                  the option of the State, the State may  
20                  allow an individual or the individual’s  
21                  representative to elect to receive self-  
22                  directed home and community-based  
23                  services in a manner which gives them  
24                  the most control over such services  
25                  consistent with the individual’s abili-

1 ties and the requirements of sub-  
2 clauses (II) and (III).

3 “(II) SELF-DIRECTED SERV-  
4 ICES.—The term ‘self-directed’ means,  
5 with respect to the home and commu-  
6 nity-based services offered under the  
7 State plan amendment, such services  
8 for the individual which are planned  
9 and purchased under the direction  
10 and control of such individual or the  
11 individual’s authorized representative,  
12 including the amount, duration, scope,  
13 provider, and location of such services,  
14 under the State plan consistent with  
15 the following requirements:

16 “(aa) ASSESSMENT.—There  
17 is an assessment of the needs, ca-  
18 pabilities, and preferences of the  
19 individual with respect to such  
20 services.

21 “(bb) SERVICE PLAN.—  
22 Based on such assessment, there  
23 is developed jointly with such in-  
24 dividual or the individual’s au-  
25 thorized representative a plan for

1 such services for such individual  
2 that is approved by the State and  
3 that satisfies the requirements of  
4 subclause (III).

5 “(III) PLAN REQUIREMENTS.—  
6 For purposes of subclause (II)(bb),  
7 the requirements of this subclause are  
8 that the plan—

9 “(aa) specifies those services  
10 which the individual or the indi-  
11 vidual’s authorized representative  
12 would be responsible for direct-  
13 ing;

14 “(bb) identifies the methods  
15 by which the individual or the in-  
16 dividual’s authorized representa-  
17 tive will select, manage, and dis-  
18 miss providers of such services;

19 “(cc) specifies the role of  
20 family members and others whose  
21 participation is sought by the in-  
22 dividual or the individual’s au-  
23 thorized representative with re-  
24 spect to such services;

1                   “(dd) is developed through a  
2 person-centered process that is  
3 directed by the individual or the  
4 individual’s authorized represent-  
5 ative, builds upon the individual’s  
6 capacity to engage in activities  
7 that promote community life and  
8 that respects the individual’s  
9 preferences, choices, and abilities,  
10 and involves families, friends,  
11 and professionals as desired or  
12 required by the individual or the  
13 individual’s authorized represent-  
14 ative;

15                   “(ee) includes appropriate  
16 risk management techniques that  
17 recognize the roles and sharing of  
18 responsibilities in obtaining serv-  
19 ices in a self-directed manner and  
20 assure the appropriateness of  
21 such plan based upon the re-  
22 sources and capabilities of the in-  
23 dividual or the individual’s au-  
24 thorized representative; and

1                   “(ff) may include an individ-  
2                   ualized budget which identifies  
3                   the dollar value of the services  
4                   and supports under the control  
5                   and direction of the individual or  
6                   the individual’s authorized rep-  
7                   resentative.

8                   “(IV) BUDGET PROCESS.—With  
9                   respect to individualized budgets de-  
10                  scribed in subclause (III)(ff), the  
11                  State plan amendment—

12                   “(aa) describes the method  
13                   for calculating the dollar values  
14                   in such budgets based on reliable  
15                   costs and service utilization;

16                   “(bb) defines a process for  
17                   making adjustments in such dol-  
18                   lar values to reflect changes in  
19                   individual assessments and serv-  
20                   ice plans; and

21                   “(cc) provides a procedure  
22                   to evaluate expenditures under  
23                   such budgets.

24                   “(H) QUALITY ASSURANCE; CONFLICT OF  
25                   INTEREST STANDARDS.—

1                   “(i)    QUALITY    ASSURANCE.—The  
2                   State ensures that the provision of home  
3                   and community-based services meets Fed-  
4                   eral and State guidelines for quality assur-  
5                   ance.

6                   “(ii) CONFLICT OF INTEREST STAND-  
7                   ARDS.—The State establishes standards  
8                   for the conduct of the independent evalua-  
9                   tion and the independent assessment to  
10                  safeguard against conflicts of interest.

11                  “(I) REDETERMINATIONS AND APPEALS.—  
12                  The State allows for at least annual redeter-  
13                  minations of eligibility, and appeals in accord-  
14                  ance with the frequency of, and manner in  
15                  which, redeterminations and appeals of eligi-  
16                  bility are made under the State plan.

17                  “(J) PRESUMPTIVE ELIGIBILITY FOR AS-  
18                  SESSMENT.—The State, at its option, elects to  
19                  provide for a period of presumptive eligibility  
20                  (not to exceed a period of 60 days) only for  
21                  those individuals that the State has reason to  
22                  believe may be eligible for home and commu-  
23                  nity-based services. Such presumptive eligibility  
24                  shall be limited to medical assistance for car-  
25                  rying out the independent evaluation and as-



1            sessment under subparagraph (E) to determine  
2            an individual's eligibility for such services and  
3            if the individual is so eligible, the specific home  
4            and community-based services that the indi-  
5            vidual will receive.

6            “(2) DEFINITION OF INDIVIDUAL'S REP-  
7            RESENTATIVE.—In this section, the term ‘individ-  
8            ual's representative’ means, with respect to an indi-  
9            vidual, a parent, a family member, or a guardian of  
10          the individual, an advocate for the individual, or any  
11          other individual who is authorized to represent the  
12          individual.

13          “(3) NONAPPLICATION.—A State may elect in  
14          the State plan amendment approved under this sec-  
15          tion to not comply with the requirements of section  
16          1902(a)(1) (relating to statewideness) and section  
17          1902(a)(10)(C)(i)(III) (relating to income and re-  
18          source rules applicable in the community), but only  
19          for purposes of provided home and community-based  
20          services in accordance with such amendment. Any  
21          such election shall not be construed to apply to the  
22          provision of services to an individual receiving med-  
23          ical assistance in an institutionalized setting as a re-  
24          sult of a determination that the individual requires  
25          the level of care provided in a hospital or a nursing

1 facility or intermediate care facility for the mentally  
2 retarded.

3 “(4) NO EFFECT ON OTHER WAIVER AUTHOR-  
4 ITY.—Nothing in this subsection shall be construed  
5 as affecting the option of a State to offer home and  
6 community-based services under a waiver under sub-  
7 sections (c) or (d) of this section or under section  
8 1115.

9 “(5) CONTINUATION OF FEDERAL FINANCIAL  
10 PARTICIPATION FOR MEDICAL ASSISTANCE PRO-  
11 VIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF  
12 STATE PLAN AMENDMENT.—Notwithstanding para-  
13 graph (1)(B), Federal financial participation shall  
14 continue to be available for an individual who is re-  
15 ceiving medical assistance in an institutionalized set-  
16 ting, or home and community-based services pro-  
17 vided under a waiver under this section or section  
18 1115 that is in effect as of the effective date of the  
19 State plan amendment submitted under this sub-  
20 section, as a result of a determination that the indi-  
21 vidual requires the level of care provided in a hos-  
22 pital or a nursing facility or intermediate care facil-  
23 ity for the mentally retarded, without regard to  
24 whether such individuals satisfy the more stringent  
25 eligibility criteria established under that paragraph,

1       until such time as the individual is discharged from  
2       the institution or waiver program or no longer re-  
3       quires such level of care.”.

4       (b) QUALITY OF CARE MEASURES.—

5           (1) IN GENERAL.—The Secretary, acting  
6       through the Director of the Agency for Healthcare  
7       Research and Quality, shall consult with consumers,  
8       health and social service providers and other profes-  
9       sionals knowledgeable about long-term care services  
10      and supports to develop program performance indi-  
11      cators, client function indicators, and measures of  
12      client satisfaction with respect to home and commu-  
13      nity-based services offered under State Medicaid  
14      programs.

15          (2) BEST PRACTICES.—The Secretary shall—

16           (A) use the indicators and measures devel-  
17           oped under paragraph (1) to assess such home  
18           and community-based services, the outcomes as-  
19           sociated with the receipt of such services (par-  
20           ticularly with respect to the health and welfare  
21           of the recipient of the services), and the overall  
22           system for providing home and community-  
23           based services under the Medicaid program  
24           under title XIX of the Social Security Act; and

1 (B) make publicly available the best prac-  
2 tices identified through such assessment and a  
3 comparative analyses of the system features of  
4 each State.

5 (3) APPROPRIATION.—Out of any funds in the  
6 Treasury not otherwise appropriated, there is appro-  
7 priated to the Secretary of Health and Human Serv-  
8 ices, \$1,000,000 for the period of fiscal years 2006  
9 through 2010 to carry out this subsection.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 subsections (a) and (b) take effect on January 1, 2007,  
12 and apply to expenditures for medical assistance for home  
13 and community-based services provided in accordance with  
14 section 1915(i) of the Social Security Act (as added by  
15 subsections (a) and (b)) on or after that date.

16 **SEC. 6087. OPTIONAL CHOICE OF SELF-DIRECTED PER-**  
17 **SONAL ASSISTANCE SERVICES (CASH AND**  
18 **COUNSELING).**

19 (a) EXEMPTION FROM CERTAIN REQUIREMENTS.—  
20 Section 1915 of the Social Security Act (42 U.S.C.  
21 1396n), as amended by section 6086(a), is amended by  
22 adding at the end the following new subsection:

23 “(j)(1) A State may provide, as ‘medical assistance’,  
24 payment for part or all of the cost of self-directed personal  
25 assistance services (other than room and board) under the

1 plan which are provided pursuant to a written plan of care  
2 to individuals with respect to whom there has been a de-  
3 termination that, but for the provision of such services,  
4 the individuals would require and receive personal care  
5 services under the plan, or home and community-based  
6 services provided pursuant to a waiver under subsection  
7 (c). Self-directed personal assistance services may not be  
8 provided under this subsection to individuals who reside  
9 in a home or property that is owned, operated, or con-  
10 trolled by a provider of services, not related by blood or  
11 marriage.

12 “(2) The Secretary shall not grant approval for a  
13 State self-directed personal assistance services program  
14 under this section unless the State provides assurances  
15 satisfactory to the Secretary of the following:

16 “(A) Necessary safeguards have been taken to  
17 protect the health and welfare of individuals pro-  
18 vided services under the program, and to assure fi-  
19 nancial accountability for funds expended with re-  
20 spect to such services.

21 “(B) The State will provide, with respect to in-  
22 dividuals who—

23 “(i) are entitled to medical assistance for  
24 personal care services under the plan, or receive

1 home and community-based services under a  
2 waiver granted under subsection (c);

3 “(ii) may require self-directed personal as-  
4 sistance services; and

5 “(iii) may be eligible for self-directed per-  
6 sonal assistance services,

7 an evaluation of the need for personal care under  
8 the plan, or personal services under a waiver granted  
9 under subsection (c).

10 “(C) Such individuals who are determined to be  
11 likely to require personal care under the plan, or  
12 home and community-based services under a waiver  
13 granted under subsection (c) are informed of the  
14 feasible alternatives, if available under the State’s  
15 self-directed personal assistance services program, at  
16 the choice of such individuals, to the provision of  
17 personal care services under the plan, or personal  
18 assistance services under a waiver granted under  
19 subsection (c).

20 “(D) The State will provide for a support sys-  
21 tem that ensures participants in the self-directed  
22 personal assistance services program are appro-  
23 priately assessed and counseled prior to enrollment  
24 and are able to manage their budgets. Additional

1       counseling and management support may be pro-  
2       vided at the request of the participant.

3           “(E) The State will provide to the Secretary an  
4       annual report on the number of individuals served  
5       and total expenditures on their behalf in the aggre-  
6       gate. The State shall also provide an evaluation of  
7       overall impact on the health and welfare of partici-  
8       pating individuals compared to non-participants  
9       every three years.

10       “(3) A State may provide self-directed personal as-  
11      sistance services under the State plan without regard to  
12      the requirements of section 1902(a)(1) and may limit the  
13      population eligible to receive these services and limit the  
14      number of persons served without regard to section  
15      1902(a)(10)(B).

16       “(4)(A) For purposes of this subsection, the term  
17      ‘self-directed personal assistance services’ means personal  
18      care and related services, or home and community-based  
19      services otherwise available under the plan under this title  
20      or subsection (c), that are provided to an eligible partici-  
21      pant under a self-directed personal assistance services pro-  
22      gram under this section, under which individuals, within  
23      an approved self-directed services plan and budget, pur-  
24      chase personal assistance and related services, and per-

1 mits participants to hire, fire, supervise, and manage the  
2 individuals providing such services.

3 “(B) At the election of the State—

4 “(i) a participant may choose to use any indi-  
5 vidual capable of providing the assigned tasks in-  
6 cluding legally liable relatives as paid providers of  
7 the services; and

8 “(ii) the individual may use the individual’s  
9 budget to acquire items that increase independence  
10 or substitute (such as a microwave oven or an acces-  
11 sibility ramp) for human assistance, to the extent  
12 that expenditures would otherwise be made for the  
13 human assistance.

14 “(5) For purpose of this section, the term ‘approved  
15 self-directed services plan and budget’ means, with respect  
16 to a participant, the establishment of a plan and budget  
17 for the provision of self-directed personal assistance serv-  
18 ices, consistent with the following requirements:

19 “(A) SELF-DIRECTION.—The participant (or in  
20 the case of a participant who is a minor child, the  
21 participant’s parent or guardian, or in the case of an  
22 incapacitated adult, another individual recognized by  
23 State law to act on behalf of the participant) exer-  
24 cises choice and control over the budget, planning,  
25 and purchase of self-directed personal assistance



1 services, including the amount, duration, scope, pro-  
2 vider, and location of service provision.

3 “(B) ASSESSMENT OF NEEDS.—There is an as-  
4 sessment of the needs, strengths, and preferences of  
5 the participants for such services.

6 “(C) SERVICE PLAN.—A plan for such services  
7 (and supports for such services) for the participant  
8 has been developed and approved by the State based  
9 on such assessment through a person-centered proc-  
10 ess that—

11 “(i) builds upon the participant’s capacity  
12 to engage in activities that promote community  
13 life and that respects the participant’s pref-  
14 erences, choices, and abilities; and

15 “(ii) involves families, friends, and profes-  
16 sionals in the planning or delivery of services or  
17 supports as desired or required by the partici-  
18 pant.

19 “(D) SERVICE BUDGET.—A budget for such  
20 services and supports for the participant has been  
21 developed and approved by the State based on such  
22 assessment and plan and on a methodology that uses  
23 valid, reliable cost data, is open to public inspection,  
24 and includes a calculation of the expected cost of  
25 such services if those services were not self-directed.

1       The budget may not restrict access to other medi-  
2       cally necessary care and services furnished under the  
3       plan and approved by the State but not included in  
4       the budget.

5           “(E) APPLICATION OF QUALITY ASSURANCE  
6       AND RISK MANAGEMENT.—There are appropriate  
7       quality assurance and risk management techniques  
8       used in establishing and implementing such plan and  
9       budget that recognize the roles and responsibilities  
10      in obtaining services in a self-directed manner and  
11      assure the appropriateness of such plan and budget  
12      based upon the participant’s resources and capabili-  
13      ties.

14      “(6) A State may employ a financial management en-  
15     tity to make payments to providers, track costs, and make  
16     reports under the program. Payment for the activities of  
17     the financial management entity shall be at the adminis-  
18     trative rate established in section 1903(a).”.

19      (b) EFFECTIVE DATE.—The amendment made by  
20     subsection (a) shall apply to services furnished on or after  
21     January 1, 2007.

## **Subtitle B—SCHIP**

### **2 SEC. 6101. ADDITIONAL ALLOTMENTS TO ELIMINATE FIS- 3 CAL YEAR 2006 FUNDING SHORTFALLS.**

4 (a) IN GENERAL.—Section 2104 of the Social Secu-  
5 rity Act (42 U.S.C. 1397dd) is amended by inserting after  
6 subsection (c) the following:

7 “(d) ADDITIONAL ALLOTMENTS TO ELIMINATE  
8 FUNDING SHORTFALLS.—

9 “(1) APPROPRIATION; ALLOTMENT AUTHOR-  
10 ITY.—For the purpose of providing additional allot-  
11 ments to shortfall States described in paragraph (2),  
12 there is appropriated, out of any money in the  
13 Treasury not otherwise appropriated, \$283,000,000  
14 for fiscal year 2006.

15 “(2) SHORTFALL STATES DESCRIBED.—For  
16 purposes of paragraph (1), a shortfall State de-  
17 scribed in this paragraph is a State with a State  
18 child health plan approved under this title for which  
19 the Secretary estimates, on the basis of the most re-  
20 cent data available to the Secretary as of December  
21 16, 2005, that the projected expenditures under  
22 such plan for such State for fiscal year 2006 will ex-  
23 ceed the sum of—

1           “(A) the amount of the State’s allotments  
2           for each of fiscal years 2004 and 2005 that will  
3           not be expended by the end of fiscal year 2005;

4           “(B) the amount, if any, that is to redis-  
5           tributed to the State during fiscal year 2006 in  
6           accordance with subsection (f); and

7           “(C) the amount of the State’s allotment  
8           for fiscal year 2006.

9           “(3) ALLOTMENTS.—In addition to the allot-  
10          ments provided under subsections (b) and (c), sub-  
11          ject to paragraph (4), of the amount available for  
12          the additional allotments under paragraph (1) for  
13          fiscal year 2006, the Secretary shall allot—

14               “(A) to each shortfall State described in  
15               paragraph (2) such amount as the Secretary  
16               determines will eliminate the estimated shortfall  
17               described in such paragraph for the State; and

18               “(B) to each commonwealth or territory  
19               described in subsection (c)(3), the same propor-  
20               tion as the proportion of the commonwealth’s or  
21               territory’s allotment under subsection (c) (de-  
22               termined without regard to subsection (f)) to  
23               1.05 percent of the amount appropriated under  
24               paragraph (1).

1           “(4) USE OF ADDITIONAL ALLOTMENT.—Addi-  
2           tional allotments provided under this subsection are  
3           only available for amounts expended under a State  
4           plan approved under this title for child health assist-  
5           ance for targeted low-income children.

6           “(5) 1-YEAR AVAILABILITY; NO REDISTRIBU-  
7           TION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—  
8           Notwithstanding subsections (e) and (f), amounts al-  
9           lotted to a State pursuant to this subsection for fis-  
10          cal year 2006 shall only remain available for expend-  
11          iture by the State through September 30, 2006. Any  
12          amounts of such allotments that remain unexpended  
13          as of such date shall not be subject to redistribution  
14          under subsection (f) and shall revert to the Treasury  
15          on October 1, 2006.”.

16          (b) CONFORMING AMENDMENTS.—Section 2104 of  
17          the Social Security Act (42 U.S.C. 1397dd) is amended—

18               (1) in subsection (a), by inserting “subject to  
19               subsection (d),” after “under this section,”;

20               (2) in subsection (b)(1), by inserting “and sub-  
21               section (d)” after “Subject to paragraph (4)”; and

22               (3) in subsection (c)(1), by inserting “subject to  
23               subsection (d),” after “for a fiscal year,”.

24          (c) EFFECTIVE DATE.—The amendments made by  
25          this section apply to items and services furnished on or

1 after October 1, 2005, without regard to whether or not  
2 regulations implementing such amendments have been  
3 issued.

4 **SEC. 6102. PROHIBITION AGAINST COVERING NONPREG-**  
5 **NANT CHILDLESS ADULTS WITH SCHIP**  
6 **FUNDS.**

7 (a) PROHIBITION ON USE OF SCHIP FUNDS.—Sec-  
8 tion 2107 of the Social Security Act (42 U.S.C. 1397gg)  
9 is amended by adding at the end the following:

10 “(f) LIMITATION OF WAIVER AUTHORITY.—Notwith-  
11 standing subsection (e)(2)(A) and section 1115(a), the  
12 Secretary may not approve a waiver, experimental, pilot,  
13 or demonstration project that would allow funds made  
14 available under this title to be used to provide child health  
15 assistance or other health benefits coverage to a nonpreg-  
16 nant childless adult. For purposes of the preceding sen-  
17 tence, a caretaker relative (as such term is defined for pur-  
18 poses of carrying out section 1931) shall not be considered  
19 a childless adult.”.

20 (b) CONFORMING AMENDMENTS.—Section  
21 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is  
22 amended—

23 (1) by inserting “and may not include coverage  
24 of a nonpregnant childless adult” after “section  
25 2101”); and

1           (2) by adding at the end the following: “For  
2           purposes of the preceding sentence, a caretaker rel-  
3           ative (as such term is defined for purposes of car-  
4           rying out section 1931) shall not be considered a  
5           childless adult.”.

6           (c) RULE OF CONSTRUCTION.—Nothing in this sec-  
7           tion or the amendments made by this section shall be con-  
8           strued to—

9           (1) authorize the waiver of any provision of title  
10          XIX or XXI of the Social Security Act (42 U.S.C.  
11          1396 et seq., 1397aa et seq.) that is not otherwise  
12          authorized to be waived under such titles or under  
13          title XI of such Act (42 U.S.C. 1301 et seq.) as of  
14          the date of enactment of this Act;

15          (2) imply congressional approval of any waiver,  
16          experimental, pilot, or demonstration project affect-  
17          ing funds made available under the State children’s  
18          health insurance program under title XXI of the So-  
19          cial Security Act (42 U.S.C. 1397aa et. seq.) or any  
20          amendment to such a waiver or project that has  
21          been approved as of such date of enactment; or

22          (3) apply to any waiver, experimental, pilot, or  
23          demonstration project that would allow funds made  
24          available under title XXI of the Social Security Act  
25          (42 U.S.C. 1397aa et seq.) to be used to provide

1 child health assistance or other health benefits cov-  
2 erage to a nonpregnant childless adult that is ap-  
3 proved before the date of enactment of this Act or  
4 to any extension, renewal, or amendment of such a  
5 waiver or project that is approved on or after such  
6 date of enactment.

7 (d) EFFECTIVE DATE.—This section and the amend-  
8 ments made by this section shall take effect as if enacted  
9 on October 1, 2005, and shall apply to any waiver, experi-  
10 mental, pilot, or demonstration project that is approved  
11 on or after that date.

12 **SEC. 6103. CONTINUED AUTHORITY FOR QUALIFYING**  
13 **STATES TO USE CERTAIN FUNDS FOR MED-**  
14 **ICAID EXPENDITURES.**

15 (a) IN GENERAL.—Section 2105(g)(1)(A) of the So-  
16 cial Security Act (42 U.S.C. 1397ee(g)(1)(A)) is amended  
17 by striking “or 2001” and inserting “2001, 2004, or  
18 2005”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) shall apply to expenditures made under title  
21 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)  
22 on or after October 1, 2005.



## **Subtitle C—Katrina Relief**

### **2 SEC. 6201. ADDITIONAL FEDERAL PAYMENTS UNDER HUR- 3 RICANE-RELATED MULTI-STATE SECTION 4 1115 DEMONSTRATIONS.**

5 (a) IN GENERAL.—The Secretary of Health and  
6 Human Services shall pay to each eligible State, from  
7 amounts appropriated pursuant to subsection (e),  
8 amounts for the following purposes:

9 (1) Under the authority of an approved Multi-  
10 State Section 1115 Demonstration Project (in this  
11 section referred to as an “section 1115 project”)—

12 (A) with respect to evacuees receiving  
13 health care under such project, for the non-  
14 Federal share of expenditures:

15 (i) for medical assistance furnished  
16 under title XIX of the Social Security Act,  
17 and

18 (ii) for child health assistance fur-  
19 nished under title XXI of such Act;

20 (B) with respect to evacuees who do not  
21 have other coverage for such assistance through  
22 insurance, including (but not limited to) private  
23 insurance, under title XIX or title XXI of the  
24 Social Security Act, or under State-funded  
25 health insurance programs, for the total uncom-

1            compensated care costs incurred for medically nec-  
2            essary services and supplies or premium assist-  
3            ance for such persons, and for those evacuees  
4            receiving medical assistance under the project  
5            for the total uncompensated care costs incurred  
6            for medically necessary services and supplies be-  
7            yond those included as medical assistance or  
8            child health assistance under the State's ap-  
9            proved plan under title XIX or title XXI of the  
10          Social Security Act;

11            (C) with respect to affected individuals re-  
12          ceiving health care under such project for the  
13          non-Federal share of the following expenditures:

14                    (i) for medical assistance furnished  
15                    under title XIX of the Social Security Act,  
16                    and

17                    (ii) for child health assistance fur-  
18                    nished under title XXI of such Act; and

19            (D) with respect to affected individuals  
20          who do not have other coverage for such assist-  
21          ance through insurance, including (but not lim-  
22          ited to) private insurance, under title XIX or  
23          title XXI of the Social Security Act, or under  
24          State-funded health insurance programs, for the  
25          total uncompensated care costs incurred for

1 medically necessary services and supplies or  
2 premium assistance for such persons, and for  
3 those affected individuals receiving medical as-  
4 sistance under the project for the total uncom-  
5 pensated care costs incurred for medically nec-  
6 essary services and supplies beyond those in-  
7 cluded as medical assistance or child health as-  
8 sistance under the State's approved plan under  
9 title XIX or title XXI of the Social Security  
10 Act.

11 (2) For reimbursement of the reasonable ad-  
12 ministrative costs related to subparagraphs (A)  
13 through (D) of paragraph (1) as determined by the  
14 Secretary.

15 (3) Only with respect to affected counties or  
16 parishes, for reimbursement with respect to individ-  
17 uals receiving medical assistance under existing  
18 State plans approved by the Secretary of Health and  
19 Human Services for the following non-Federal share  
20 of expenditures:

21 (A) For medical assistance furnished under  
22 title XIX of the Social Security Act.

23 (B) For child health assistance furnished  
24 under title XXI of such Act.

1           (4) For other purposes, if approved by the Sec-  
2       retary under the Secretary's authority, to restore ac-  
3       cess to health care in impacted communities.

4       (b) DEFINITIONS.—For purposes of this section:

5           (1) The term “affected individual” means an  
6       individual who resided in an individual assistance  
7       designation county or parish pursuant to section 408  
8       of the Robert T. Stafford Disaster Relief and Emer-  
9       gency Assistance Act, as declared by the President  
10      as a result of Hurricane Katrina and continues to  
11      reside in the same State that such county or parish  
12      is located in.

13          (2) The term “affected counties or parishes”  
14      means a county or parish described in paragraph  
15      (1).

16          (3) The term “evacuee” means an affected indi-  
17      vidual who has been displaced to another State.

18          (4) The term “eligible State” means a State  
19      that has provided care to affected individuals or  
20      evacuees under a section 1115 project.

21      (c) APPLICATION TO MATCHING REQUIREMENTS.—  
22      The non-Federal share paid under this section shall not  
23      be regarded as Federal funds for purposes of Medicaid  
24      matching requirements, the effect of which is to provide

1 fiscal relief to the State in which the Medicaid eligible indi-  
2 vidual originally resided.

3 (d) TIME LIMITS ON PAYMENTS.—

4 (1) No payments shall be made by the Sec-  
5 retary under subsection (a)(1)(A) or (a)(1)(C), for  
6 costs of health care provided to an eligible evacuee  
7 or affected individual for services for such individual  
8 incurred after June 30, 2006.

9 (2) No payments shall be made by the Sec-  
10 retary under subsection (a)(1)(B) or (a)(1)(D) for  
11 costs of health care incurred after January 31,  
12 2006.

13 (3) No payments may be made under sub-  
14 section (a)(1)(B) or (a)(1)(D) for an item or service  
15 that an evacuee or an affected individual has re-  
16 ceived from an individual or organization as part of  
17 a public or private hurricane relief effort.

18 (e) APPROPRIATIONS.—For the purpose of providing  
19 funds for payments under this section, in addition to any  
20 funds made available for the National Disaster Medical  
21 System under the Department of Homeland Security for  
22 health care costs related to Hurricane Katrina, including  
23 under a section 1115 project, there is appropriated out  
24 of any money in the Treasury not otherwise appropriated,  
25 \$2,000,000,000, to remain available to the Secretary until

1 expended. The total amount of payments made under sub-  
2 section (a) may not exceed the total amount appropriated  
3 under this subsection.

4 **SEC. 6202. STATE HIGH RISK HEALTH INSURANCE POOL**  
5 **FUNDING.**

6 (a) IN GENERAL.—There are hereby authorized and  
7 appropriated for fiscal year 2006—

8 (1) \$75,000,000 for grants under subsection  
9 (b)(1) of section 2745 of the Public Health Service  
10 Act (42 U.S.C. 300gg-45); and

11 (2) \$15,000,000 for grants under subsection (a)  
12 of such section.

13 (b) TREATMENT.—The amount appropriated  
14 under—

15 (1) paragraph (1) shall be treated as if it had  
16 been appropriated under subsection (c)(2) of such  
17 section; and

18 (2) paragraph (2) shall be treated as if it had  
19 been appropriated under subsection (c)(1) of such  
20 section.

21 (c) REFERENCES.—Effective upon the enactment of  
22 the State High Risk Pool Funding Extension Act of  
23 2005—

1           (1) subsection (a)(1) shall be applied by sub-  
2       stituting “subsections (b)(2) and (c)(3)” for “sub-  
3       section “(b)(1)”;

4           (2) subsection (b)(1) shall be applied by sub-  
5       stituting “(d)(1)(B)” for “(c)(2)”;

6           (3) subsection (b)(2) shall be applied by sub-  
7       stituting “(d)(1)(A)” for “(c)(1)”.

8       **SEC. 6203. IMPLEMENTATION FUNDING.**

9       For purposes of implementing the provisions of, and  
10      amendments made by, title V of this Act and this title—

11           (1) the Secretary of Health and Human Serv-  
12      ices shall provide for the transfer, in appropriate  
13      part from the Federal Hospital Insurance Trust  
14      Fund established under section 1817 of the Social  
15      Security Act (42 U.S.C. 1395i) and the Federal  
16      Supplementary Medical Insurance Trust Fund es-  
17      tablished under section 1841 of such Act (42 U.S.C.  
18      1395t), of \$30,000,000 to the Centers for Medicare  
19      & Medicaid Services Program Management Account  
20      for fiscal year 2006; and

21           (2) out of any funds in the Treasury not other-  
22      wise appropriated, there are appropriated to such  
23      Secretary for the Centers for Medicare & Medicaid  
24      Services Program Management Account,  
25      \$30,000,000 for fiscal year 2006.